SERVICE CAPACITY ASSESSMENT

PRIORITY MENTAL HEALTH SERVICES 2018

JULY 20, 2018

Arizona Health Care Cost Containment System

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CONTENTS

1

EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid Agency, engaged Mercer Government Human Services Consulting (Mercer) to implement a network sufficiency evaluation of four prioritized mental health services available to persons determined to have a serious mental illness (SMI) in Maricopa County, Arizona. This report represents the fifth in a series of annual service capacity assessments performed by Mercer.

The service capacity assessment included an evaluation of the availability, assessed need and provision of supported housing, supported employment, consumer operated services (peer support services and family support services), and assertive community treatment (ACT). Mercer assessed service capacity of the priority mental health services utilizing the following methods:

- *Key informant surveys, interviews and focus groups:* Surveys and interviews were completed with key informants and focus groups were conducted with members, family members, case managers and providers.
- *Medical record reviews*: A sample ("Group 1") of members' assessments and ISPs were compared to recipient perceptions regarding the extent to which needs for the priority services were assessed and incorporated into service planning. Recipient perspectives were obtained during interviews conducted by peer specialists employed by two separate consumer operated organizations under contract with Mercer. A second sample of class members ("Group 2") was drawn to support an evaluation of clinical assessments, ISPs, and progress notes to examine the extent to which recipient's needs for the priority services were being assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services*: Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. Additional progressive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services.
- *Analysis of outcomes data:* Analysis of data including homeless prevalence, employment data, and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

OVERVIEW OF FINDINGS AND RECOMMENDATIONS

Findings and recommendations regarding the accessibility and provision of the priority services are summarized below. When applicable and available, comparisons of findings and results from prior year reviews are presented. The review period primarily targeted calendar year 2017 (CY 2017), though for some units of analysis that rely on service utilization data, the timeframe was extended (i.e., October 2016 – June 30, 2017) to account for potential lags in processing fully adjudicated administrative claims data.

SERVICE CAPACITY ASSESSMENT CONCLUSIONS

Mercer's current service capacity assessment identified that the recently expanded capacity of priority mental health services as established and documented in prior year service capacity assessments was sustained. 1,272 additional SMI members accessed covered services compared to the previous year.

The extent of the assessed need for the services appears to be within the system's contracted capacity to provide each of the prioritized services. For example, ACT team capacity across the 24 available teams was found to be 93% at the time of the service capacity assessment. Based on a national study by leading ACT researchers, a benchmark of 4.3% was used to estimate the percentage of adults with SMI served in the mental health system who need the ACT level of care[1]. With an ACT penetration rate of 7%, Maricopa County exceeds the benchmark for access to ACT team services. Key informant interviews with clinic co-located supported employment providers reveal that capacity exists in excess of the current demand for supported employment services. Supported housing providers continue to add new members into permanent support housing supports and services and, based on the multi-evaluation component analysis, do not appear to be exceeding contracted capacity. One noted and persistent exception is the lack of available housing vouchers with extended wait lists reported for some SMI members.

While it appears that sufficient capacity is available for each of the prioritized mental health services, opportunities continue to exist to strengthen clinical processes and promote awareness of the appropriate application of the services. Mercer found that 33 (27%) of the 121 Group 1 cases did not include a current assessment and/or individual service plan. While many of these members may be challenging for the clinical teams to engage, regular assessments and updates to service plans ensure that members are periodically evaluated and any needs for the priority services are identified and addressed. As recently as April 2018, the Maricopa County Regional Behavioral Health Authority (RBHA) reported that, across the network of contracted providers and clinics, 88% of individual service plans and 89% of assessments are current.[2] However, the RBHA report is based on monthly provider self-reports. During a telephonic interview in May 2018, RBHA representatives indicated that there is currently no systematic process in place to assess the validity of the provider self-reported data. Based on Mercer's recent experience with reviewing medical record documentation, it is recommended that the RBHA establish a process to validate the provider self-reported data regarding current assessments and individual service plans.

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[1] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

[2] Correspondence from MMIC on May 25, 2018.

As noted last year, there was evidence to indicate that members of the clinical teams (case managers and clinical supervisors) could benefit from additional training regarding the appropriate application of covered services, including many of the priority mental health services (i.e., supported employment, family support, and peer support). For this review cycle, Mercer again observed multiple ISPs with identified services that were inappropriate to meet the member's stated needs, goals and objectives.

More robust efforts may be needed to identify appropriate candidates for ACT team services. A review of high cost data demonstrated that over 65% of members with the highest service costs are not currently assigned to an ACT team, even when members placed in residential settings were excluded from the analysis. Alternatively, it was challenging for Mercer to identify medical record documentation that suggested clinical teams were reviewing opportunities for current ACT team members to step down to less intensive levels of care.

Sufficient access to the prioritized mental health services is critical to support members' recovery goals and ensure positive outcomes. The Maricopa County RBHA has implemented a value-based purchasing initiative and is monitoring designated performance measures associated with improved member outcomes. The purpose of the initiative is to encourage continuous quality improvement and learning, particularly initiatives that target improved health outcomes and cost savings. AHCCCS has led this effort and is leveraging the managed care model toward value-based health care with the expectation to improve members' health care experience and overall population health. Performance measure results reported by the RBHA that are directly relevant to the Maricopa County SMI population and the priority mental health services are summarized below (data for Contract Year 2017). [3]

For ACT team providers, findings include:
- Psychiatric hospitalizations per 1000 members have decreased 21% (compared to an 8% reduction in the prior year);
- Medical hospitalizations per 1000 members have decreased 12%;
- Emergency department visits per 1000 members have decreased by 11% (compared to a 6% reduction in the prior year);
- Members competitively employed per 1000 have increased 100%; and
- Homelessness per 1000 members has decreased by 19%.

For Forensic ACT team providers, findings include:
- A forensic ACT team achieved a 57% reduction in the number of jail bookings;
- A 54% reduction in psychiatric hospital admissions (compared to a 31% reduction in the prior year);
- An 27% reduction in emergency department visits (compared to an 18% reduction in the prior year); and
- A 45% reduction in medical hospital admissions.

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[3] As reported by the Maricopa County RBHA, correspondence dated May 11, 2018.

For permanent supporting housing providers, findings include:
- A 52% reduction in psychiatric hospital admissions was observed for members affiliated with a participating supported housing service provider;
- A 40% reduction in the number of members who utilized a mobile crisis service; and
- 99.6% of members maintained stable housing once secured.

A summary of findings specific to each priority mental health service are presented below.

Consumer Operated Services (Peer Support Services and Family Support Services)
- Service utilization data reveals a sustained level in the percentage of members who received at least one unit of peer support services during the review period. During CY 2017, 37% of members received peer support services representing the second highest percentage observed since CY 2013 and CY 2016. (CY 2013 – 38%; CY 2014 – 31%; CY 2015 – 29%; CY 2016 – 38%).
- Service utilization data shows minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY 2013 – 2%; CY 2014 – 3%; CY 2015 – 2%; CY 2016; CY 2017 – 2%).
- Participants in all focus groups expressed that clinical teams do not consistently demonstrate an understanding of the appropriate role of the peer support specialist, peer or recovery navigator and/or family support specialist. This lack of clarity has led to confusion regarding how to best utilize these resources. In particular, many family member focus group attendees reported that they were not aware of the availability of peer support or family support specialists or how to access them if needed.
- Most survey respondents felt that peer support services were easy to access (83%). 8% of survey respondents indicated that peer support services were difficult to access and none of the respondents indicated that the services were inaccessible. Consistent with the last four years, peer support services were perceived as the easiest of all the priority services to access.
- For most of the assessments reviewed, the clinical teams identify and document natural and family supports that are important to the member. Most of the records reviewed included evidence that family supports were identified by the clinical team. Family support services can be an effective intervention for family members to develop skills to interact and support the person in the home and community. Despite the clinical team's identification of natural and family supports, individual service plans rarely included family support services.
- Maricopa County excels in making peer support services available to persons in recovery. The penetration rates for 2016 and 2017 are relatively high and represent a national best practice benchmark in terms of access to peer support.
- Over 30% of all members who received at least one unit of peer support during the review period accessed the service for more than two consecutive months.
- The Mercer review team regularly identified the misapplication of priority mental health services by the member's assigned clinical team, including family support. The most prominent misunderstanding is recognizing that family support is an intervention directed to and performed *with the member's family member(s)* with the goal of promoting the family's ability to effectively interact and support the member.

- As reported by the Maricopa County RBHA, peer support and family support contracted capacity is capable of serving at least 2,215 members[4].

Supported Employment Services

- Service utilization data demonstrates that 26% of members received at least one unit of supported employment during CY 2017, the same finding as last year. (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%; CY 2016 – 26%).
- Focus group participants reported an increase in the number of Vocational Rehabilitation (VR) specialists co-located at the clinics. While there is noted variation in the timely access to VR services, participants expressed that the increased availability of VR specialists is a positive development.
- Participants in the provider and case manager focus groups stated that members are encouraged to pursue a wider variety of employment opportunities outside of peer support specialist training and employment. Provider organizations are now co-located at the clinics leading to more diverse opportunities for members. Case manager participants also reported that they continue to observe an increase in the number of employers willing to hire individuals with SMI diagnoses.
- Nearly fifty-five percent of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month. Mercer was unable to discern if this finding is predominantly the result of rapid job placement or if a majority of members are unable to sustain ongoing involvement in supported employment services.
- 17% of survey respondents expressed that supported employment services were difficult to access, comparable to last year (21%) and significantly less than CY 2013 and CY 2014 (75% – CY 2013; 33% – CY 2014). 83% of respondents indicated that supported employment services were easy to access or having "fair" access, an increase from CY 2016 (79%) and significantly higher than CY 2014 (66%).
- Based on the review of medical records, Mercer identified the following issues:
  - Assessed needs and corresponding individual service plan interventions are commonly misaligned and suggest that some clinical teams responsible for developing the service plan in coordination with the member do not fully understand the appropriate application of the priority mental health services, including supported employment.
  - Individual service plans are not always based on the member's assessed needs and can include generic language that does not differentiate each member's unique circumstances and needs.
  - The most prevalent reason noted by Mercer's review team for why members don't access services identified on the individual service plan is that there is a lack of documentation that the clinical team followed up with referring and coordinating access to the service(s). However, if the services identified on the individual service plan are not consistently based on the member's assessed needs as illustrated by a subset of the sample of medical records; the member may have never required the service in the first place.

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[4] Correspondence from MMIC on May 25, 2018.

- Consistent with patterns noted over the past four years, the service utilization data set shows proportional variation in the volume of encountered service codes for supported employment. For the time period October 1, 2016 through June 30, 2017, H2027 (pre-job training and development) accounts for 94% of the total supported employment services (increase from CY 2016 – 87%).
- Department of Economic Security/Rehabilitation Services Administration (DES/RSA) data secured from the Maricopa County RBHA includes the following:
  - RBHA members referred to RSA/Vocational Rehabilitation (VR) – 2,844 (January 1, 2017 – November 30, 2017)
  - RBHA member served in the VR program – 1,789 (quarter ending September 30, 2017)
  - RBHA members open in the VR program – 1,519 (quarter ending September 30, 2017
  - RBHA members in service plan status with VR – 938 (quarter ending September 30, 2017)
- As reported by the Maricopa County RBHA, supported employment contracted capacity is capable of serving at least 770 members.

Supported Housing Services
- Service utilization data reveals that 7% of members received at least one unit of supported housing during the review period.
- Focus group participants expressed concerns about increasing prices in local market rent which can contribute to a lack of housing capacity. Participants also noted that many apartment complexes are being renovated, resulting in increases in rent and a reduction in lease renewals for members.
- 42% of the survey respondents felt that supported housing services were difficult to access, down from 46% a year ago. Four percent of the respondents indicated that supported housing services were inaccessible, a significant improvement from CY 2013 when 17% of the key informants felt that supported housing services were inaccessible.
- In twenty-eight cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.
- As reported by the Ma`ricopa County RBHA, permanent supported housing contracted capacity is capable of serving at least 1,265 members.

ACT Team Services
- As a percentage of the total SMI population, 7% of all members are assigned to an ACT team. This is the same finding observed in CY 2015 and CY 2016, and slightly higher than the finding derived during CY 2013 and CY 2014 (6%).
- Mercer completed an analysis of service utilization data for recipients that were assigned to an ACT team. CY 2017 service utilization profiles for 2,056 ACT team members who received a behavioral health service were analyzed. The analysis found that 72% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 44%. Utilization of supported housing services was found to be 18% across the identified ACT team members.
- A review of 100 SMI members that represent the highest aggregate behavioral health service costs during CY 2017 was conducted. It was determined that 26% of the members were assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013, 18% during CY 2014, 23% during CY 2015 and 25% during CY 2016. Of the 26 members assigned to

ACT and included on the list of the top 100 members with the highest behavioral health service costs; 9 (36%) also resided in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. Overall, 41 of the 100 (41%) members resided in a supervised behavioral health residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a supervised behavioral health residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 33% of the highest cost utilizers are assigned to an ACT team.

- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January 2017 through November 2017) and determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:
  - 391 members experienced at least two jail bookings during the period under review (467 for same time period in CY 2016; 408 for same time period in CY 2015).
  - Of these 391 members, 63 (16%) were assigned to an ACT team (CY 2016 – 25%; CY 2015 – 23%) during the review period.
  - Of the 63 members assigned to an ACT team, 18 (29%) are assigned to a forensic specialty ACT team (CY 2016 – 22%; CY 2015 – 20%).
  - 22 members receiving ACT team services have 3 or more incarcerations over the review period, but are not assigned to one of the three available forensic specialty ACT teams.
- 2,233 members were assigned to 24 ACT teams as of December 1, 2017. The same number of teams as CY 2016, but an increase of 141 members.

Additional and more detailed findings and recommendations for each of the priority services can be found in *Section 5, Findings and Recommendations.*

2
OVERVIEW

AHCCCS engaged Mercer to implement an annual network sufficiency evaluation of four prioritized mental health services available to persons determined to have a SMI.[5] The service capacity assessment included a need and allocation evaluation of supported housing, supported employment, consumer operated services (peer support services and family support services), and ACT.

GOALS AND OBJECTIVES OF ANALYSES

The primary objectives of the service capacity assessment were designed to answer the following questions regarding the prioritized mental health services. For each of the four prioritized services:

- What is the extent of the assessed need for the service?
- When a need for the service is identified, are recipients able to timely access the service for the intensity and duration commensurate with the person's clinical needs?
- What factors (e.g., capacity, quality, system design) most commonly impact the appropriate assessment of need and/or ability to access the service?
- Identify system strengths and opportunities to improve the appropriate identification of need and access to the prioritized mental health services.

LIMITATIONS AND CONDITIONS

Mercer did not independently verify the accuracy and completeness of service utilization data, outcomes data, and other primary source information collected from AHCCCS. Service utilization data includes encounter submission lag times that are known to impact the completeness of the data set. Mercer performed an analysis of summary level service utilization data related to the four prioritized mental health services and aggregated available functional and clinical outcomes data.

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[5] The determination of SMI requires both a qualifying SMI diagnosis and functional impairment as a result of the qualifying diagnosis.

3

BACKGROUND

During the review period, AHCCCS served as the single State authority to provide coordination, planning, administration, regulation, and monitoring of all facets of the State public behavioral health system. AHCCCS contracts with managed care organizations, known as RBHAs, to administer integrated physical health (to select populations) and behavioral health services throughout the State of Arizona. AHCCCS administers and oversees the full spectrum of services to support integration efforts at the health plan, provider and member levels.

HISTORY OF ARNOLD V. SARN

In 1981, a class action lawsuit was filed alleging that the State, through the Arizona Department of Health Services and Maricopa County, did not adequately fund a comprehensive mental health system as required by State statute. The lawsuit, *Arnold v. Sarn*, sought to enforce the community mental health residential treatment system on behalf of persons with SMI in Maricopa County. Furthermore, the severe State budget crisis in the past decade resulted in significant funding reductions to class members, a temporary stay in enforcement of the lawsuit, and agreement by the parties to renegotiate exit criteria.

On May 17, 2012, as the State's fiscal situation was improving, former Arizona Governor Jan Brewer, State health officials, and plaintiffs' attorneys announced a two-year agreement that included a return of much of the previously reduced funding for a package of recovery-oriented services including supported employment, living skills training, supported housing, case management, and expansion of organizations run by and for people living with SMI. The two-year agreement included activities aimed to assess the quality of services provided, member outcomes, and overall network sufficiency.

On January 8, 2014, a final agreement was reached in the *Arnold v. Sarn* case. The final settlement provides a variety of community-based services and programs agreed upon by the State and plaintiffs, including crisis services; supported employment and housing services; ACT; family and peer support; life skills training; and respite care services. The State was required to adopt national quality standards outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), as well as annual quality service reviews conducted by an independent contractor and an independent service capacity assessment to evaluate the delivery of care to the State's SMI population.

SMI SERVICE DELIVERY SYSTEM

Beginning July 1, 2016, AHCCCS contracted with RBHAs to deliver integrated physical health (to select populations) and behavioral health services in three geographic service areas (GSAs) across Arizona. Each RBHA must manage a network of providers to deliver all covered physical health and behavioral health services to Medicaid eligible persons determined to have an SMI. RBHAs contract with

behavioral health providers to provide the full array of covered physical health and behavioral health services, including the four prioritized mental health services that are the focus of this assessment.

For persons determined to have an SMI in Maricopa County, the RBHA has contracts with two adult provider network organizations (PNOs) and multiple administrative entities that manage ACT teams and/or operate direct care clinics throughout the county. The PNOs and administrative entities include, Partners in Recovery Network, Southwest Network, Terros, Lifewell Behavioral Wellness, LaFrontera/EMPACT, Chicano Por La Causa, Community Bridges, Inc., Assurance Health and Wellness, Jewish Family and Children's Service and Maricopa Integrated Health System. The table below identifies the adult PNOs and administrative entities and assigned direct care clinics[6].

ORGANIZATION	DIRECT CARE CLINICS	ORGANIZATION	DIRECT CARE CLINICS
Terros	Priest	**Southwest Network**	Saguaro
	23rd Avenue		Highland
	51st Avenue		San Tan
			Bethany Village
			Estella Village
			Mesa Heritage
			Royal Palms
Lifewell Behavioral Wellness	Oak	**Chicano Por La Causa**	Centro Esperanza
	Windsor		
	South Mountain		
		Maricopa Integrated Health system	First Episode Center
LaFrontera/EMPACT	Comunidad	**Partners in Recovery Network**	Metro Center Campus
	EMPACT – San Tan		West Valley Campus

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[6] Excludes clinics established to serve members assigned to ACT teams.

ORGANIZATION	DIRECT CARE CLINICS	ORGANIZATION	DIRECT CARE CLINICS
	EMPACT – SPC Apache Junction		Arrowhead Campus
			East Valley Campus
			Hassayampa Campus
			Gateway Campus

The direct care clinics provide a range of recovery focused services to SMI recipients such as medication services, medical management, case management, transportation, peer support services, family support services, and health and wellness groups. 24 ACT teams are available at different direct care clinics and community provider locations. Access to other covered behavioral health services, including supported employment and supported housing is primarily accessible to SMI recipients through RBHA contracted community-based providers.

CURRENT SERVICE CAPACITY

The information presented below reflects the contracted capacity for each of the prioritized services during the period under review.[7]

ACT Teams (24 teams serving 2,233 recipients)[8]

PNO/DIRECT CARE CLINIC	SPECIALTY	CAPACITY	NUMBER OF RECIPIENTS	% BELOW FULL CAPACITY
Southwest Network: San Tan		100	98	2%
Southwest Network: Saguaro		100	85	15%
Southwest Network: Mesa Heritage		100	93	7%
Southwest Network: Osborn		100	93	7%
Southwest Network: Royal Palms		100	98	2%
Lifewell Behavioral Wellness: South Mountain		100	97	3%

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[7] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2018.
[8] As of December 1, 2017.

| PNO/DIRECT CARE CLINIC	SPECIALTY	CAPACITY	NUMBER OF RECIPIENTS	% BELOW FULL CAPACITY
Terros: Enclave		100	100	0%
Terros: Townley	Primary Care Provider (PCP) Partnership	100	93	7%
Terros: Townley 2		100	98	2%
Terros: 51st Avenue	PCP Partnership	100	97	3%
Chicanos Por La Causa: Centro Esperanza		100	99	1%
LaFrontera/EMPACT: Tempe	PCP Partnership	100	91	9%
LaFrontera/EMPACT: Comunidad		100	93	7%
LaFrontera/EMPACT: Capitol Center		100	95	5%
Partners in Recovery: Metro Center Campus – Omega Team		100	99	1%
Partners in Recovery: Metro Center Campus – Varsity Team		100	97	3%
Partners in Recovery: Indian School	Medical Team	100	90	10%
Partners in Recovery: West Valley Campus	PCP Partnership	100	95	5%
Community Bridges: FACT Team 1	Forensic Team & PCP Partnership	100	92	8%
Community Bridges: FACT Team 2	Forensic Team & PCP Partnership	100	90	10%
Community Bridges: FACT Team 3	Forensic Team & PCP Partnership	100	89	11%
Community Bridges: Avondale	PCP Partnership	100	93	7%
Community Bridges: 99th Avenue*	PCP Partnership	100	67	33%

PNO/DIRECT CARE CLINIC	SPECIALTY	CAPACITY	NUMBER OF RECIPIENTS	% BELOW FULL CAPACITY
Maricopa Integrated Health System – Mesa Riverview	PCP Partnership	100	91	9%
	Totals	2,400	2,233	7%

* Represent new ACT teams since the last review.

A presentation of service utilization data is depicted below to identify the volume of units and unique members affiliated with each provider. The review is intended to identify the largest providers of the priority services. The analysis was completed for the following priority mental health services: peer support, family support, supported employment and supported housing.

**Consumer Operated Services (peer support and family support)[9]**
- Assurance Health and Wellness
- CHEEERS
- Chicanos Por La Causa (CPLC)
- Community Bridges, Inc.
- Family Involvement Center
- Hope Lives Vive la Esperanza
- La Frontera/EMPACT
- Lifewell Behavioral Wellness
- Marc Community Resources
- Maricopa Integrated Health System (MIHS)
- National Council on Alcoholism and Drug
- Dependence (NCADD)
- NAZCARE
- Partners in Recovery
- Phoenix Shanti
- PSA
- Recovery Empowerment Network (REN)
- Recovery Innovations International
- Southwest Behavioral Health

Top peer support providers, by units

Top peer support providers, by members served
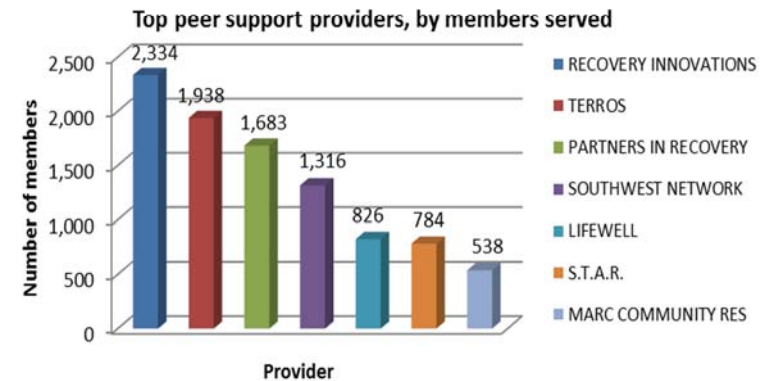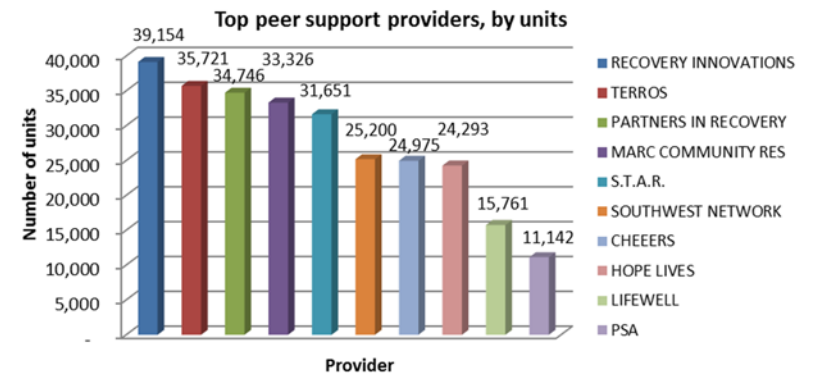
[9] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2018.

- Southwest Network
- Stand Together and Recover (STAR)
- Terros
- Valle de Sol

**Consumer Operated Services (family support)[10]**

Top family support providers, by units

Top family support providers, by members served

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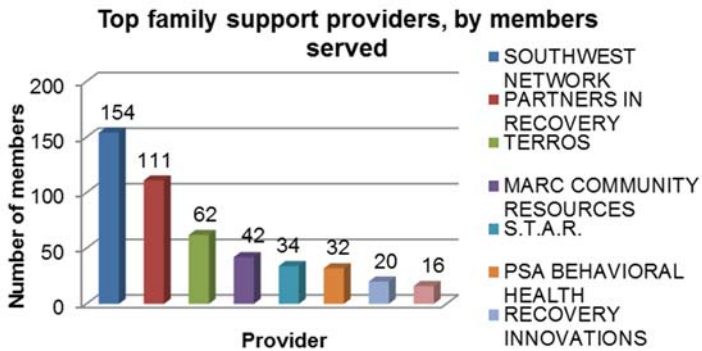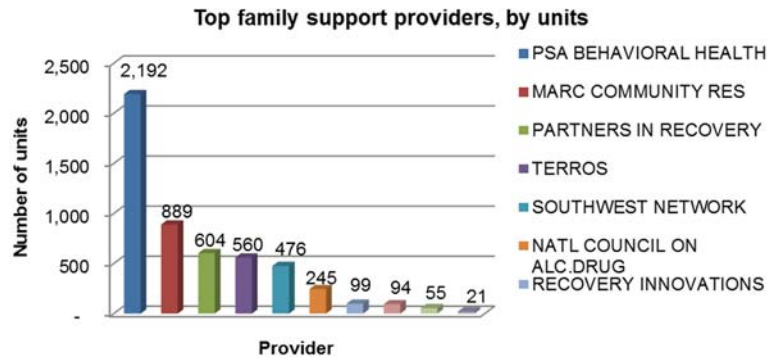
[10] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2018.
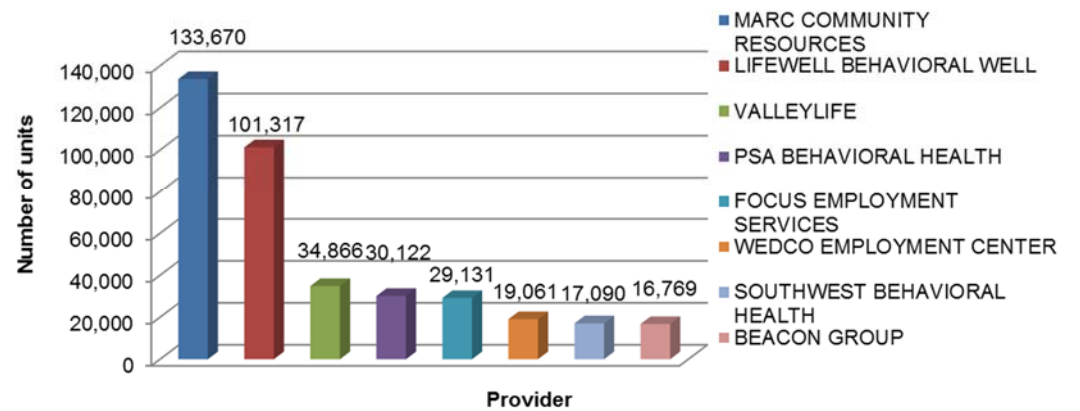
Supported Employment Providers[11]
- Beacon Group
- Focus Employment Services
- Lifewell Behavioral Wellness
- Marc Community Resources
- Recovery Empowerment Network
- Valleylife
- Wedco

Top supported employment providers, by members served
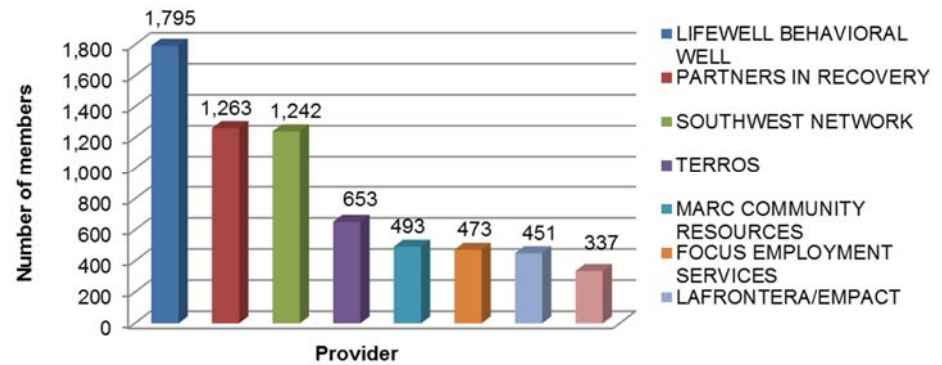
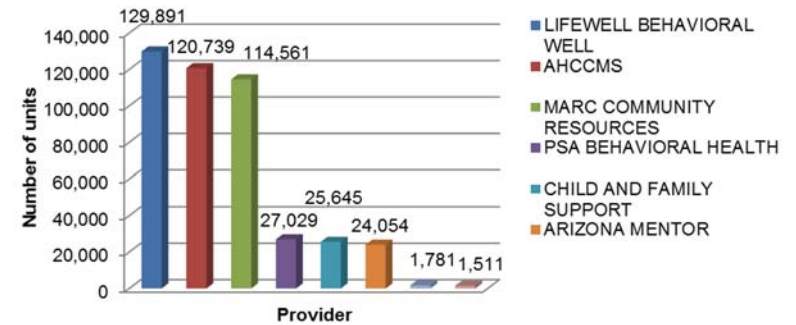Top supported employment providers, by units

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[11] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2018.
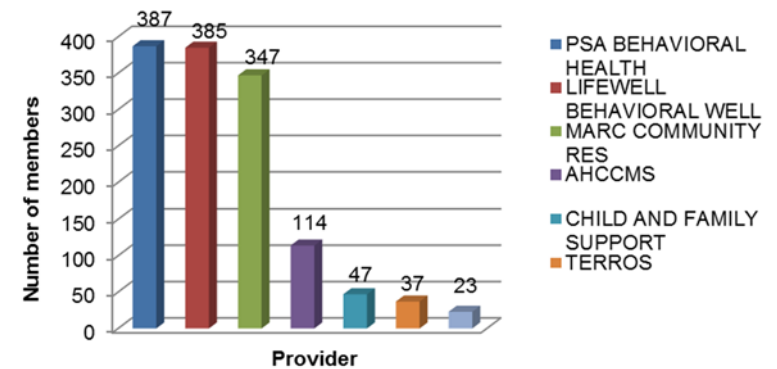
Supported Housing Providers[12]

- A New Leaf
- Arizona Behavioral Health Corporation
- Arizona Health Care Contract Management Services (AHCCMS)
- Biltmore Properties
- Chicano Por La Causa
- Child and Family Support Services
- Community Bridges, Inc.
- Florence Crittenton
- Housing Authority of Maricopa County
- Lifewell Behavioral Wellness
- Marc Community Resources
- Native American Connections
- ProMarc
- PSA Behavioral Health Agency
- RI International
- Save the Family
- Southwest Behavioral Health Services
- Terros

Top supported housing providers, by units

Provider	Number of units
LIFEWELL BEHAVIORAL WELL	129,891
AHCCMS	120,739
MARC COMMUNITY RESOURCES	114,561
PSA BEHAVIORAL HEALTH	27,029
CHILD AND FAMILY SUPPORT	25,645
ARIZONA MENTOR	24,054
	1,781
	1,511

Top supported housing providers, by members served

Provider	Number of members
PSA BEHAVIORAL HEALTH	387
LIFEWELL BEHAVIORAL WELL	385
MARC COMMUNITY RES	347
AHCCMS	114
CHILD AND FAMILY SUPPORT	47
TERROS	37
	23

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[12] As reported by the Maricopa County RBHA administering the AHCCCS contract in January 2018.

4

METHODOLOGY

Mercer performed a service capacity assessment of the priority mental health services to assess unmet needs utilizing the following methods:

- *Key informant surveys, interviews and focus groups:* Surveys and interviews were completed with key informants and focus groups were conducted with members, family members, case managers and providers.
- *Medical record reviews*: A sample ("Group 1") of members' assessments and ISPs were compared to recipient perceptions regarding the extent to which needs for the priority services were assessed and incorporated into service planning. Recipient perspectives were obtained during interviews conducted by peer specialists employed by two separate consumer operated organizations under contract with Mercer. A second sample of class members ("Group 2") was drawn to support an evaluation of clinical assessments, ISPs, and progress notes to examine the extent to which recipient's needs for the priority services were being assessed and met.
- *Analysis of service utilization data and contracted capacity for each of the priority mental health services*: Analysis was conducted to evaluate the volume of unique users, billing units, and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to estimate "persistence" in treatment. Persistence was evaluated by calculating the proportion of recipients who only received a priority service during a single month. Additional progressive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in the selected prioritized services.
- *Analysis of outcomes data:* Analysis of data including homeless prevalence, employment data, and criminal justice information.
- *Benchmark analysis:* Analysis of priority service penetration rates in other states and local systems that represent relevant comparisons for Maricopa County.

A description of the methodology utilized for each evaluation component is presented below.

FOCUS GROUPS

As part of the service capacity assessment of the priority behavioral health services in Maricopa County, four focus groups were conducted with key informants. The focus groups were organized and managed to facilitate discussion with participants who have direct experience with the priority mental health services.

Participation in the focus groups was solicited by an invitation created by Mercer, which was reviewed and approved by AHCCCS[13].

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[13] See Appendix A: Focus Group Invitation.

Notification of the annual Service Capacity Assessment focus groups was communicated to key stakeholders in the community. This included email communications and electronic invitations sent to the Adult PNOs, administrative entities, providers of the priority mental health services and to family and peer run organizations.

The focus groups targeted the following participants:
- Providers of supported housing services, supported employment services, ACT team services, and peer and family support services.
- Family members of SMI adults receiving behavioral health services.
- SMI adults receiving behavioral health services.
- Direct care clinic case managers.

A total of 31 stakeholders participated in the four two-hour focus groups conducted on February 21, 2018 and February 23, 2018. All four focus groups were held at the Refuge Cafe. Invitations to voluntarily participate in the focus groups were distributed to a defined list of stakeholders and the actual number of participants does not represent a statistically significant sample. As such, focus group results should be reviewed in the context of qualitative and supplemental data and should not be interpreted to be representative of the total population of potential focus group participants.

The methodology included the following approach:
- A handout defining each of the priority mental health services was provided to each group of participants at the onset of the focus groups.
- Participants were prompted to discuss experiences related to accessing each of the priority services, including perceived system strengths and barriers.
- Based on findings derived from the prior year's evaluation, participants were asked to share observations regarding any noted system changes, improvements and/or ongoing and emerging concerns regarding the availability and capacity of the priority mental health services.

KEY INFORMANT SURVEYS AND INTERVIEWS

One objective of the service capacity assessment was to obtain comprehensive stakeholder feedback regarding the availability of each of the priority mental health services. As a result, a key informant survey was created using *Survey Monkey®*. The survey tool included questions with rating assignments related to accessing the priority mental health services, including the ease of access and timeliness of access to the services.[14] The survey distribution approach targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

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[14] See Appendix B: Key Informant Survey.

The survey was disseminated to key system stakeholders via email with a hyperlink to the online survey. A total of 24 respondents completed the survey tool.

In addition, multiple in-depth interviews were conducted with providers of the targeted services and other community stakeholders to gather information regarding system strengths and potential barriers to accessing the priority mental health services.

MEDICAL RECORD REVIEWS (GROUP 1 AND GROUP 2)

Mercer obtained two separate samples for the record reviews that were conducted. The first sample ("Group 1") focused on the extent to which the attempts of clinical team members to assess and attend to needs for priority services matched the recipient's perceptions of their need for the services, as determined through direct recipient interviews.

In reviewing the records of the second sample ('Group 2"), Mercer evaluated clinical assessments, ISPs, and clinical team progress notes to determine the extent to which needs for priority services were being considered in service planning and met through service provision. Both groups consisted of adults with SMI who were widely distributed across PNOs, direct care clinics, and levels of case management (i.e., assertive, supportive, and connective).

The total sample size across both groups is 320. With a population of 31,712, this sample size has a confidence level of </=92% with a margin of error of 5%.

Group 1

The Group 1 sample included 121 randomly selected cases.

The Group 1 medical record review sought to answer the following questions regarding the assessment process and determination that assessed needs were addressed as part of the recipient's ISP:
- Is there evidence that each of the priority mental health services was assessed by the clinical team?
- When assessed as a need, is the priority mental health service(s) identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for one or more of the priority mental health services?

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, and the recipient's current ISP.

Mercer developed an interview guide[15] to support the assessment of the recipient's perception regarding the need for one or more of the priority services. Mercer's review team trained peer reviewers regarding the use of the interview tool to help ensure consistent application of the guide across reviewers.

All 121 Group 1 recipients completed in-person interviews.

Group 1 medical record documentation for the sample (n=121) was reviewed by Mercer behavioral health professionals and recorded in a data collection tool. Documentation regarding the priority mental health services was analyzed by reviewing assessments and ISPs, the findings from which were recorded in the data collection tool. Findings from the recipient interviews were added to the data collection tool to support a comparative analysis between the medical record documentation findings and the recipient's recorded responses to the interview questions.

Group 2

For Group 2, the final sample included 199 randomly chosen cases stratified by PNO and clinic and selected using the following parameters:
- The recipient was identified as SMI and received a covered behavioral health service during October 1, 2016 and December 31, 2017.[16]
- The recipient had an assessment date between January 1 and November 15, 2017.[17]

The Group 2 medical record review sought to answer the following questions regarding the assessment and provision of the priority mental health services:
- Is there evidence that the need for each of the priority mental health services was assessed by the clinical team?
- When assessed as a need, was the priority mental health service(s) identified on the recipient's ISP?
- When identified as a need and listed on the recipient's ISP, is there evidence that the recipient accessed the service consistent with the prescribed frequency and duration and within a reasonable time period?
- If the recipient was unable to access the recommended priority service, what were the reasons that the service(s) was not delivered?

Medical record documentation was requested for each recipient identified in the sample. Requested documents included the recipient's current annual assessment update or initial assessment and/or a current psychiatric evaluation, the recipient's current ISP, and all clinical team progress notes following each recipients' assessment date through December 31, 2017.

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[15] See Appendix C: Assessment Verification Interview Tool.

[16] The total population of unique SMI recipients who received behavioral health services is 31,712 for the period October 1, 2016 through December 31, 2017.

[17] Cases for Group 2 were selected to ensure that sufficient time had elapsed to reasonably expect the delivery of recommended services following the completion of the recipient's assessment and ISP.

Group 2 medical record documentation for the sample (n=199) was reviewed by three licensed clinicians and recorded in a data collection tool.[18] Additional comments were recorded to further clarify findings. Prior to conducting the medical record reviews, inter-rater reliability testing was completed over a two-day period with the reviewers using actual cases, resulting in 97% agreement between reviewers across all scoring tool questions.

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ANALYSIS OF SERVICE UTILIZATION DATA

Mercer initiated a request to AHCCCS for a comprehensive service utilization data file. The service utilization data file included all adjudicated service encounters for any person designated as SMI and assigned to the Maricopa County GSA.

The specified time frame for the file included dates of service between October 1, 2016 and December 31, 2017. As noted in previous service capacity assessment reports, encounter submission lag times can impact the completeness of the data set.

Specific queries were developed to identify the presence of each prioritized mental health service.[19] Analysis was conducted to evaluate the volume of unique users, billing units and rendering providers. In addition to the percentage of recipients who received one or more of the prioritized services, an analysis was completed to determine "persistence" in treatment. Through the evaluation, proportions of recipients who only received the service in a single month were calculated. Additional progressive consecutive time intervals were also created (two to three months, three to four months, five to six months, seven to eight months, and nine months) to determine the volume of recipients who sustained consistent participation in each of the prioritized services. For ACT team services, a roster of ACT team members was obtained and a corresponding analysis of service utilization was also performed.

The service utilization data file supports the extraction of the Group 1 and Group 2 medical record samples and allows for an analysis of the service utilization profile for each recipient selected, as well as supporting an aggregated view of service utilization for each sample group (total sample size across Group 1 and Group 2 = 320). Group 1 and Group 2 sample characteristics for each year of the service capacity assessment are illustrated in the following tables and are compared to the characteristics of the total population of active users.

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[18] See Appendix D: Group 2 Medical Record Review Tool.

[19] ACT team services are one of the identified prioritized mental health services reviewed as part of the service capacity assessment. However, ACT team services are not assigned a unique billing code and; therefore, are not represented in the service utilization data file.

2017 Service Capacity Assessment Time Period – Utilization

SAMPLE GROUP	NUMBER OF RECIPIENTS	PEER SUPPORT	FAMILY SUPPORT	SUPPORTED EMPLOYMENT	SUPPORTED HOUSING	ACT
Group 1	121	36%	2%	27%	9%	3%
Group 2	199	49%	2%	35%	9%	18%[20]
Service utilization data	31,712	37%	2%	26%	7%	7%[21]

2016 Service Capacity Assessment Time Period – Utilization

SAMPLE GROUP	NUMBER OF RECIPIENTS	PEER SUPPORT	FAMILY SUPPORT	SUPPORTED EMPLOYMENT	SUPPORTED HOUSING	ACT
Group 1	121	45%	7%	45%	14%	4%
Group 2	199	36%	5%	27%	9%	11%
Service utilization data	30,440	38%	3%	26%	10%	7%

2015 Service Capacity Assessment Time Period – Utilization

SAMPLE GROUP	NUMBER OF RECIPIENTS	PEER SUPPORT	FAMILY SUPPORT	SUPPORTED EMPLOYMENT	SUPPORTED HOUSING	ACT
Group 1	119	24%	1%	18%	3%	2%
Group 2	201	30%	4%	21%	3%	4%
Service utilization data	24,608	29%	2%	17%	4%	7%

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[20] The Group 2 sampling methodology was stratified by provider and clinic. The provider group was expanded to include ACT providers when serving as the member's primary behavioral health medical home. The inclusion of this type of ACT provider was new this year and increased the proportion of the sample receiving ACT services.

[21] ACT services were not included as part of the service utilization file, but based on the current ACT roster, 7% of all active SMI recipients are assigned to ACT teams.

2014 Service Capacity Assessment Time Period – Utilization

SAMPLE GROUP	NUMBER OF RECIPIENTS	PEER SUPPORT	FAMILY SUPPORT	SUPPORTED EMPLOYMENT	SUPPORTED HOUSING	ACT
Group 1	124	29%	2%	10%	2%	6%
Group 2	197	30%	3%	18%	4%	4%
Service utilization data	24,048	31%	3%	20%	3%	6%

2013 Service Capacity Assessment Time Period – Utilization

SAMPLE GROUP	NUMBER OF RECIPIENTS	PEER SUPPORT	FAMILY SUPPORT	SUPPORTED EMPLOYMENT	SUPPORTED HOUSING	ACT
Group 1	122	36%	2%	39%	0%	7%
Group 2	198	40%	3%	32%	0%	4%
Service utilization data	23,512	38%	2%	39%	0.02%	6%

ANALYSIS OF OUTCOMES DATA

The service capacity assessment utilized an analysis of member outcome data in an attempt to correlate receipt of one or more of the priority mental health services with improved functional outcomes. Based on the available data and the desire to compare year-to-year results, the review team selected the following outcome indicators to support the analysis:

• Criminal justice records (i.e., number of arrests);
• Homeless prevalence (i.e., primary residence); and
• Employment status.

The outcome indicators listed above are described as part of the AHCCCS Demographic and Outcomes Data Set User Guide, which provides information for the completion and submission of the demographic data set, a set of data elements that RBHAs are required to collect and submit to AHCCCS. The data is used to:

• Monitor and report on recipients' outcomes;
• Comply with federal, State, and/or grant requirements to ensure continued funding for the behavioral health system;
• Assist with financial-related activities such as budget development and rate setting;
• Support quality management and utilization management activities; and
• Inform stakeholders and community members.

The data fields contained in the demographic data set are mandatory and must be collected and submitted within required timeframes, recorded using valid values, and in compliance with specified definitions.

The outcomes data was provided by AHCCCS as part of the service utilization data file request. For each member included in the service utilization file, AHCCCS provided abstracts of the most recent demographic data record.

AHCCCS has established valid values for recording each demographic data element, including the selected functional outcomes. Each indicator is described and valid selections are presented below.

Number of Arrests
The outcome indicator records the number of times that the recipient has been arrested within the last 30 days. A valid entry is the number of times (between 0 and 31).

Primary Residence
The outcome indicator is described as the place where the recipient has spent most of his/her time in the past 30 days prior to the assessment. Valid values include:
- Independent
- Hotel
- Boarding home
- Supervisory care/assisted living
- Arizona state hospital
- Jail/prison/detention
- Homeless/homeless shelter
- Other
- Foster home or therapeutic foster home
- Nursing home
- Home with family
- Crisis shelter
- Level I, II, or III behavioral health treatment setting
- Transitional housing (Level IV) or Department of Economic Security group homes for children

Employment Status
The outcome indicator records the recipient's current employment status. Valid values include:
- Unemployed
- Volunteer
- Unpaid rehabilitation activities

- Homemaker
- Student
- Retired
- Disabled
- Inmate of institution
- Competitive employment full-time
- Competitive employment part-time
- Work adjustment training
- Transitional employment placement
- Unknown

PENETRATION AND PREVALENCE ANALYSIS

As part of the service capacity assessment, a review of utilization and penetration rates of the priority mental health services ACT, supported employment, supported housing, and peer support[22]) was conducted. Penetration rates were compared to benchmarks, as described below.

The following review process was completed by Mercer:
- Select academic publications were reviewed;
- Mercer consulted with national experts regarding the prioritized services and benchmarks for numbers served; and
- National data from the SAMHSA on evidence-based practice (EBP) penetration rates at the state level were reviewed.

The intent in reviewing these sources was to identify average benchmarks for EBP penetration, as well as to look at best practice benchmarks. *Average benchmarks* are drawn from national averages and other sources that do not necessarily represent a best practice level of effort, whereas *best practice benchmarks* are drawn from the highest-performing systems included in the study.

SERVICE EXPANSIONS — COMPARISON OF SELECT STATES

During the initial year of the service capacity assessment, a comparative analysis was performed with selected states and included a review of negotiated agreements to increase capacity and services to populations of persons identified to have serious and persistent mental illness, as well as interviews with key state staff involved in the implementation of each state's settlement agreements. Each state reviewed has proposed service expansions for one or more of the prioritized services. The review supports a comparison of other states with Maricopa County's agreement to expand service capacity. States reviewed included Delaware, New Hampshire, and North Carolina as each state have negotiated settlements that include many of the same priority services for comparable populations. For the 2018 Service Capacity Assessment, Mercer researched each state to update and track progress as applicable and available.

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[22] Peer support services are not currently reported on the SAMHSA Mental Health National Outcome Measures (NOMS) report.

5

FINDINGS AND RECOMMENDATIONS

Findings and recommendations associated with each of the priority mental health services is summarized for each evaluation component that was applied to support the service capacity assessment. As part of each summary, key findings and recommendations are identified to address how effectively the overall service delivery system is performing to identify and meet member needs through the provision of the priority mental health services.

The distinct evaluation components that were applied as part of the service capacity assessment are listed below:
- Penetration and prevalence analysis
- Service expansions — comparison of select states
- Multi-evaluation component analysis:
    - Focus groups
    - Key informant survey data
    - Medical record reviews Group 1
    - Medical record reviews Group 2
    - Service utilization data
    - Outcomes data analysis

SMI PREVALENCE AND PENETRATION — OVERVIEW OF FINDINGS

Penetration is defined as the percentage of individuals who received services among the estimated number of individuals considered eligible for services during a defined time period. As depicted in the table below, a relatively small percentage (25%) of the estimated number of adults with SMI are served through the publicly funded system in Maricopa County. The penetration rate is below the national penetration rate of 37%, and also below that of communities of relatively similar size. For example, in Texas, Harris County (Houston) and Bexar County (San Antonio) have higher penetration rates than Maricopa County (43% and 44%, respectively). However, within the Maricopa County Medicaid system, the penetration rate (46%) exceeds the national average (37%) and, both the number of adults with SMI served and the overall penetration rate in the county increased from 2016 to 2017. The overall lower penetration rate for Maricopa County compared to some other states and counties appears to be due to the relatively low penetration rate among people without Medicaid coverage (8%).

The Maricopa County system excels in certain areas of EBP utilization. For example, supported housing and supported employment are more available in Maricopa County (especially to Medicaid recipients) compared to national averages. Maricopa County also has strong access to peer support services; at a level that is considered a "best practice benchmark." In addition, Maricopa County has more ACT teams than most comparison communities included in this analysis. More than 2,200 people received ACT services in 2017. Based on a national study by leading ACT researchers, a benchmark of 4.3% was used to estimate the percentage of adults with SMI served in the

mental health system who need the ACT level of care.[23] With an ACT penetration rate of 7%, Maricopa County exceeds the benchmark for access to ACT team services. Many other systems of care do not achieve that level of penetration. In addition, Maricopa County has three Forensic ACT teams that attend to the needs of adults with SMI who have historically high utilization of the criminal justice system.

Table 1. Service System Penetration Rates for Persons with Serious Mental Illness

PENETRATION RATES					
Region	Adult Population (≥18 Years Old)[24]	Estimated Rate of SMI in the Adult Population[25]	Estimated Number of Adults with SMI in the Pop.[26]	Number of Adults with SMI Served[27]	Penetration Rate Among Adults with SMI[28]
United States	250,999,300	4.1%	10,366,271	3,790,370	37%
Arizona	5,280,401	4.0%	213,328	44,264	21%
Maricopa County[29]	3,203,463	4.0%	129,420	31,712	25%

[23] Cuddeback, G.S., Morrissey, J.P., & Cusack, K.J. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

[24] All state-level population estimates are based on the 2017 SAMHSA estimation methodology sourced from the Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2010 to July 1, 2016. U.S. Census Bureau. Population Division. Release Date, June 2017.

[25] SAMHSA. (2017). State Estimates of Serious Mental Illness from the 2016 National Surveys on Drug Use and Health. National Survey on Drug Use and Health Report. Retrieved from https://www.samhsa.gov/data/us_map?map=1. The estimated rate of SMI statewide for Arizona was used for all Maricopa County adults. Please note that the estimated rate of SMI in the adult population was lower than what we reported in the past. This is due to some changes in the methodology used by the National Survey on Drug Use and Health. See *National Survey on Drug Use and Health: Comparison of 2012-2013 and 2013-2014 Population Percentages (50 States and the District of Columbia).*

[26] Calculation: Estimated SMI rate multiplied by adult population.

[27] The state-level proportion of people served with an SMI is reported from SAMHSA (2016) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/us_map. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI according to state-level estimates of SMI from the National Survey of Drug Use and Health (2016).

[28] Number of adults with SMI served within the system (for states, see calculation note above), divided by the estimated number of adults with SMI in the total adult population.

[29] Maricopa County data received through analysis of the service utilization data file.

PENETRATION RATES					
Region	Adult Population (≥18 Years Old)[24]	Estimated Rate of SMI in the Adult Population[25]	Estimated Number of Adults with SMI in the Pop.[26]	Number of Adults with SMI Served[27]	Penetration Rate Among Adults with SMI[28]
Maricopa County – Medicaid	482,644[30]	11.7%	56,469	25,725	46%
Maricopa County Gen. Adult Pop.	2,720,819	3.2%	72,951	5,987	8%
Texas	20,451,733	3.3%	666,726	270,270	41%
Harris County (Houston)	3,283,415	4.6%	151,037	65,000	43%
Bexar County (San Antonio)	1,391,536	4.5%	62,480	27,564	44%
New York	15,539,698	4.1%	634,020	426,314	67%
New York County (New York City)	1,643,734	4.1%	67,064	28,144	42%
Colorado	4,245,301	4.6%	195,708	71,891	37%
Denver City-County[31]	552,369	4.6%	25,464	14,246	56%
Nebraska	1,427,004	4.2%	59,506	12,121	20%
California	29,998,731	3.6%	1,082,954	347,004	32%
Illinois	9,845,795	3.7%	368,233	51,342	14%
Kansas	2,171,321	4.4%	94,887	18,330	19%
Minnesota	4,229,310	4.3%	179,746	120,351	67%
Wisconsin	4,488,084	4.2%	190,295	33,623	18%

[30] The adult population for Medicaid is based on the estimated proportion of eligible Medicaid members who are adults, versus children/youth, according to the Arizona Health Care Cost Containment System's Acute Enrollment CYE 2017 report and Demographic report for July and October 2017. Retrieved from https://archive.azahcccs.gov/ and https://www.azahcccs.gov/Resources/Reports/population.html, respectively.

[31] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016 2017, and 2018.

PENETRATION RATES					
Region	Adult Population (≥18 Years Old)[24]	Estimated Rate of SMI in the Adult Population[25]	Estimated Number of Adults with SMI in the Pop.[26]	Number of Adults with SMI Served[27]	Penetration Rate Among Adults with SMI[28]
Tennessee	5,128,792	5.0%	255,414	198,627	78%
Indiana	5,054,982	4.9%	249,211	81,099	33%
Delaware	744,260	4.2%	31,482	6,374	20%
New Hampshire	1,072,724	5.1%	54,387	12,014	22%
North Carolina	7,739,758	4.7%	365,317	83,285	23%

Overview of EBP Utilization Benchmark Analyses

Data in the table below depict the penetration rates for ACT, supported employment, and supported housing among those adults with SMI served in the Maricopa County behavioral health system. Maricopa County has an ACT penetration rate of 7%, which is at a best practice level.[32] The county's penetration rates for supported housing and supported employment services exceed the national average benchmarks. Maricopa County's supported employment penetration rate of 26% compares to a national average of under 2% and only trails two of the 14 states included in the benchmark analysis. (Delaware and New Hampshire have even higher penetration rates). The penetration rate for supported housing (7%) nearly triples the national average, and is greater than the penetration rate found in 11 of the other 14 states included in the analysis. Only Kansas, Nebraska and New York had higher supported housing penetration rates.

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[32] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

Table 2. EBP Utilization Rates Among Persons with SMI Who Were Served in the System[33]

EBP UTILIZATION RATES						
	Assertive Community Treatment		**Supported Employment (SE)**		**Supported Housing**	
Region	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**	**Number of Adults with SMI Using EBP**	**Percentage of Adults with SMI Using EBP**
United States	68,820	1.8%	64,987	1.7%	86,206	2.3%
Arizona	N/A[34]	N/A	10,400	23.5%	2,396	5.4%
Maricopa County	2,233	7.0%	8,168	25.8%	2.098	6.6%
Maricopa County – Medicaid	1,940	7.5%	7,081	27.5%	1,974	7.7%
Maricopa County – Non-Medicaid	293	4.9%	1,087	18.2%	124	2.1%
Maricopa County (SE ongoing)[35]	N/A	N/A	1,708	5.4%	N/A	N/A
New Hampshire	992	8.3%	3,525	29.3%	N/A	N/A
North Carolina	6,842	8.2%	1,159	1.4%	1,119	1.3%
Texas	4,986	1.8%	12,921	4.8%	12,379	4.6%
Harris County (Houston)	152	0.2%	2,789	4.3%	1,082	1.7%

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[33] National and state-level data on the number of people utilizing EBPs are reported from: SAMHSA (2016). *Mental Health NOMS: Central Mental Health Services Uniform Reporting System.* Retrieved from https://www.samhsa.gov/data/us_map. Rates are based on number with SMI served in the system.

[34] Arizona did not report the number of people served with ACT statewide.

[35] We conducted a second analysis of supported employment utilization, including ongoing support to maintain employment but excluding pre-job training and development. Mercer found in its 2013 review of clinical records that the latter services (pre-job training and development), which accounted for 94% of SE services coded, often indicated brief discussions with clients about employment, outside of the context of a comprehensive, evidence-based supported employment program. The 1,708 people receiving "SE ongoing" services represent a subset of consumers receiving evidence-based SE. However, it is important to note that we do not know the extent to which other states' reporting of SE references the full-evidence based model.

EBP UTILIZATION RATES

Region	Assertive Community Treatment		Supported Employment (SE)		Supported Housing	
	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Bexar County (San Antonio)	110	0.4%	1,100	4.0%	3,139	11.4%
New York	6,314	1.5%	1,958	0.5%	22,895	5.4%
New York County (NY City)	940	3.3%	N/A	N/A	8,168[36]	29%
Colorado	3,376	4.7%	504	0.7%	269	0.4%
Denver City-County (MHCD)[37]	633	4.4%	415	2.9%	1,447	10.2%
Nebraska	79	0.7%	652	5.4%	895	7.4%
California	6,396	1.8%	582	0.2%	1,552	0.4%
Illinois	903	1.8%	2,003	3.9%	N/A	N/A
Kansas	N/A	N/A	1,285	7.0%	2,461	13.4%
Minnesota	1,935	1.6%	1,007	0.8%	459	0.4%
Wisconsin	4,126	12.3%	864	2.6%	752	2.2%
Tennessee	232	0.1%	484	0.2%	1,150	0.6%
Indiana	756	0.9%	1,483	1.8%	4,147	5.1%
Delaware	1,700	26.7%	3,500	54.9%	47	0.7%

[36] Includes adults served annually in state-run clinics, as reported in: New York State Office of Mental Health. (2016). Chapter Eight: New York City DSRIP Region Needs Assessment. Retrieved from https://www.omh.ny.gov/omhweb/special-projects/dsrip/mh-substance-use-disorders.html on April 27, 2018. Data is based on NYSOMH MHARS database, CY 2014.

[37] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver, Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016, 2017 and 2018.

Changes in EBP Utilization from 2013 through 2017

The table on the next page compares utilization of ACT, supported employment, and supported housing in Maricopa County from 2013 through 2017. Highlights of the findings in comparing utilization/penetration across those five years include the following:

- *ACT*. Overall, there have been steady increases in the number of adults with SMI who received ACT services. Although the penetration rate decreased between 2013 and 2014, it exceeded the 2013 baseline from 2015 to 2017. There has been a slight increase in the penetration of ACT (from 6.7% in 2013 to 7.0% in 2017), but that is somewhat misleading — the number of people receiving ACT increased by 64% over that same time period. The penetration rate has increased only slightly because the number of people served in the system has increased dramatically from 2013 to 2017.

- *Supported Empl*oyment. The overall penetration rate for supported employment dropped from 2013 to 2014, and then dropped further in 2015. This may have been due to a decrease in the reported number of people receiving pre-job training and development services, because the number of people receiving ongoing support to maintain employment services (which is more reflective of evidence-based supported employment) actually increased from 2013 to 2014, and then again in 2015. In 2016 and 2017, Maricopa County reported a significant increase in penetration rates for both supported employment and ongoing support to maintain employment. The number of people receiving ongoing supported employment has more than tripled since 2013, and the penetration rate has more than doubled.

- *Supported Housing*. In previous years, the analysis for supported housing penetration was informed by a single supported housing billing code that was infrequently utilized (H0043). As a result, changes in the supported housing penetration rate could not be calculated between 2013 and 2014. A slight improvement in supported housing utilization was evident in the overall percentage of adults with SMI using supported housing from 2014 to 2015; the penetration rate increased from 3.3% to 3.7% (using H0043). A broader array of billing codes were added in 2016 and 2017 to reflect utilization of supported housing services when performed by a contracted supported housing provider. The supported housing penetration rate increased from 3.7% in 2015 to 9.7% in 2016, and fell to 6.6% in 2017. The revised service utilization methodology was applied in 2016 and 2017.

Table 3. Maricopa County EBP Utilization Rates: 2013-2017

MARICOPA COUNTY EBP UTILIZATION RATES AMONG PEOPLE WITH SMI SERVED IN THE SYSTEM							
		Assertive Community Treatment		Supported Employment		Supported Housing	
Year	Number of Adults with SMI Served	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP[38]	Percentage of Adults with SMI Using EBP	Number of Adults with SMI Using EBP	Percentage of Adults with SMI Using EBP
Maricopa County (2017)	31,712	2,233	7.0%	8,168	25.8%	2,098	6.6%
SE Ongoing				1,708	5.4%		
Maricopa County (2016)	30,440	2,093	6.9%	7,930	26.1%	1,408	4.6%
SE Ongoing				1,547	5.1%		
Maricopa County (2015)	24,608	1,693	6.9%	4,230	17.2%	902	3.7%
SE Ongoing				725	3.0%		
Maricopa County (2014)	23,977	1,526	6.4%	5,634	23.4%	793	3.3%
SE Ongoing				657	2.7%		
Maricopa County (2013)	20,291	1,361	6.7%	7,366	36.3%	No Data	No Data
SE Ongoing				515	2.5%		

ACT Benchmarks

Over the past few years, Maricopa County has enhanced capacity to provide ACT team services to people with SMI. An important 2006 study by Cuddeback, Morrissey, and Meyer reported that an estimated 4.3% of adults within a mental health system with SMI need the ACT level of care in any given year. The Maricopa County ACT penetration rate, relative to all people with SMI served in the system, as well as relative to the 4.3% estimate provided by Cuddeback, et al. is presented in the table below.

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[38] The number of people with SMI receiving supported employment includes a very high percentage who only received pre-job training and development employment services and no other aspects of the evidence-based supported employment model. However, those receiving "SE Ongoing" likely are receiving the full evidence-based package of SE services.

Maricopa County's ACT penetration rate (7%) exceeds the benchmark in the Cuddeback study (4.3%), compares favorably with other communities nationally, and should be considered a best practice benchmark level, especially given that Maricopa County includes FACT teams that can respond to the special needs of adults with SMI who also have histories of criminal justice system involvement. Many communities do not have any FACT teams and these teams represent a vital resource in Maricopa County.

Table 4. ACT Utilization Relative to Estimated Need among People with SMI

ACT UTILIZATION					
Region	Number of Adults with SMI Served in Public System[39]	Number with SMI Who Need ACT[40]	Number Received ACT[41]	ACT Penetration	
				Percent of All People with SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
Ideal Benchmark[42]				4.3%	100%
United States	3,790,370	162,986	68,820	1.8%	42%
Arizona	44,264	1,903	N/A	N/A	N/A
Maricopa Co. – AHCCCS Total	31,712	1,364	2,233	7.0%	164%
Maricopa Co. – Medicaid	25,725	1,106	1,940	7.5%	175%

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[39] The state-level proportion of people served with an SMI is reported from: SAMHSA (2016) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/us_map. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI according to state-level estimates of SMI from the National Survey of Drug Use and Health (2016).

[40] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806. This study examined the prevalence of people with SMI who need an ACT level of care and concluded that 4.3% of adults with SMI receiving mental health services needed an ACT level of care. The authors stipulated people with SMI needed ACT level of care if they met three criteria: received treatment for at least one year for a qualifying mental health disorder; had been enrolled in SSI or SSDI and in treatment for at least two years, and had three or more psychiatric hospitalizations within a single year.

[41] National and state-level penetration counts for ACT received are reported from: SAMHSA. (2016). Mental Health NOMS: Central Mental Health Services Uniform Reporting System. Arizona was among the states that did not report the number receiving ACT statewide.

[42] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

ACT UTILIZATION

Region	Number of Adults with SMI Served in Public System[39]	Number with SMI Who Need ACT[40]	Number Received ACT[41]	ACT Penetration	
				Percent of All People with SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
Maricopa Co. – Gen Adult Pop	5,987	293	293	4.9%	114%
New Hampshire	12,014	517	992	8.3%	192%
North Carolina	83,285	3,581	6,842	8.2%	191%
Texas	270,270	11,622	4,986	1.8%	43%
Harris County (Houston)	65,000	2,795	152	0.2%	5%
Bexar County (San Antonio)	27,564	1,185	110	0.4%	9%
New York	426,314	18,332	6,314	1.5%	34%
New York County (NY City)	28,144	1,210	940	3.3%	78%
Colorado	71,891	3,091	3,376	4.7%	109%
Denver County (MHCD)[43]	14,246	613	633	4.4%	103%
King County (Seattle, WA)	83,414	959	90	<1%	9%
Nebraska	12,121	521	79	<1%	15%
California	347,004	14,921	6,396	1.8%	43%
Illinois	51,342	2,208	903	1.8%	41%
Minnesota	120,351	5,175	1,935	1.6%	37%
Wisconsin	33,623	1,446	4,126	12.3%	285%

[43] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016, 2017 and 2018.

ACT UTILIZATION					
Region	Number of Adults with SMI Served in Public System[39]	Number with SMI Who Need ACT[40]	Number Received ACT[41]	**ACT Penetration**	
				Percent of All People with SMI Who Received ACT	Percent of the Number in Need of Act Who Received ACT
Tennessee	198,627	8,541	232	0.1%	3%
Indiana	81,099	3,487	756	0.9%	22%
Delaware	6,374	274	1,700	26.7%	620%

Supported Employment Benchmarks

Maricopa County meets a high percentage of the estimated need for supported employment services, although there is a smaller percentage of people who appear to be receiving ongoing support to maintain employment services. More than 8,000 people received pre-job training and development services, but fewer received services associated with obtaining and maintaining a job.

Nevertheless, in 2017, Maricopa County's 12% penetration rate for ongoing supported employment services, which is more likely to be consistent with high fidelity supported employment, compared fairly well to national benchmarks. It exceeded the United States' penetration rate of 4% and, among all comparison communities, it only trailed two benchmark states — New Hampshire and Kansas.

Table 5. Supported Employment Utilization Relative to Estimated Need among Persons with SMI

SUPPORTED EMPLOYMENT (SE) UTILIZATION					
Region	Number of Adults with SMI Served in System[44]	Number of People in Need of SE[45]	Number of People Who Received SE[46]	SE Penetration	
				Percent Served Among People with SMI	Percent Served Among People Who Need SE
Ideal Benchmark				45%	100%
United States	3,790,370	1,705,666	64,987	2%	4%
Arizona	44,264	19,919	10,400	4%	52%
Maricopa Co. – Total served	31,712	14,270	8,168	26%	57%
Maricopa Co. (SE Ongoing)	31,712	14,270	1,708	5%	12%
Maricopa Co. – Medicaid	25,725	11,576	7,081	28%	61%
Medicaid (SE Ongoing)	25,725	11,576	1,553	6%	13%
Maricopa Co. – Gen Adult Pop	5,987	2,694	1,087	18%	40%
Non-Medicaid (SE Ongoing)	5,987	2,694	155	3%	6%
New Hampshire	12,014	5,406	3,525	14%	32%
Texas	83,285	37,478	1,159	1%	3%
Harris County (Dallas)	270,270	121,621	12,921	7%	15%

[44] The state-level proportion of people served with an SMI is reported from: SAMHSA (2016) *Mental Health NOMS: Central for Mental Health Services Uniform Reporting System*. Retrieved from https://www.samhsa.gov/data/us_map. For states, we calculated the number of people with SMI served in a system by multiplying the reported total number of adults served by the percentage of people identified in a system as living with SMI according to state-level estimates of SMI from the National Survey of Drug Use and Health (2016).

[45] Approximately 90% of consumers with SMI are unemployed. Consumer preference research suggests approximately 50% desire to work. These two proportions are applied to the estimated SMI population to determine the estimated number of consumers who need supported employment.

[46] National and state-level penetration supported employment counts are reported from: SAMHSA (2016). Mental Health NOMS: Central Mental Health Services Uniform Reporting System.

SUPPORTED EMPLOYMENT (SE) UTILIZATION				
Region	**Number of Adults with SMI Served in System[44]**	**Number of People in Need of SE[45]**	**Number of People Who Received SE[46]**	**SE Penetration**	
				Percent Served Among People with SMI	**Percent Served Among People Who Need SE**
Bexar County (San Antonio)	65,000	29,250	2,789	2%	4%
New York	27,564	12,404	1,100	1%	2%
Colorado	426,314	191,841	1,958	<1%	1%
Denver County (MHCD)[47]	71,891	32,351	504	2%	4%
Nebraska	14,246	6,411	415	3%	7%
California	347,004	156,152	582	<1%	<1%
Illinois	51,342	23,104	2,003	3%	6%
Kansas	18,330	8,249	1,285	7%	15%
Minnesota	120,351	54,158	1,007	1%	2%
Wisconsin	33,623	15,130	864	3%	7%
Tennessee	198,627	89,382	484	<1%	1%
Indiana	81,099	36,495	1,483	2%	4%
Delaware	6,374	2,868	3,500	<1%	<1%

Peer Support Benchmarks

Maricopa County excels in making peer support services available to persons in need. The penetration rates for 2016 and 2017 are relatively high and represent a best practice benchmark in terms of access to peer support.

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[47] Data based on Mental Health Center of Denver, the largest community-based provider of services to people with SMI in Denver Colorado. Personal communication with clinical/administrative directors Roy Starks and Kristi Mock of the Mental Health Center of Denver, 2015, 2016, 2017 and 2018.

Table 6. Peer Support Penetration Rates

PEER SUPPORT		
Region	Peer Support Received	Peer Support Penetration Rate
Arizona		
Maricopa County (Total) – 2017	11,803	37%
Maricopa County (Total) – 2016	11,629	38%
Maricopa County (Total) – 2015	7,173	29%
Maricopa County (Total) – 2014	7,522	31%
Maricopa County (Total) – 2013	8,385	38%
Texas		
Harris County	3,550	5%
Colorado		
Denver City-County	170	1%
Delaware	2,400	8%
New Hampshire	2,685	5%

SERVICE EXPANSIONS — COMPARISONS WITH SELECTED STATES

A comparative analysis supported by a review of negotiated agreements to increase capacity and services to individuals with SMI was performed among selected states. This analysis consisted of a review of state published reports respective to settlement agreements and to the provision of EBPs. The results provide an informative set of contextual and comparative evidence concerning the opportunities and challenges states have experienced with their settlement agreement implementations. States reviewed included

Delaware,[48,49] New Hampshire,[50] and North Carolina,[51] each of which has negotiated settlements that included many of the same proposed service expansions and priority services for comparable populations that were included in Maricopa County's settlement.

How does Maricopa County's agreement to expand service capacity compare to other states that have negotiated similar agreements for comparable populations?

ACT Team Services

Maricopa County has exceeded its ACT expansion goals for FY 2017 by operating 24 ACT teams (three of which are FACT teams) capable of serving 2,400 members. As was mentioned earlier in the report, published estimates of the need for ACT indicate that 4.3% of adults in a mental health system with SMI need ACT, and Maricopa County has exceeded this figure.[52]

Achieving the milestones for ACT team services appears to be the area in which most of the other states reported success. Delaware[53,54] and North Carolina each met their settlement agreement benchmarks for ACT team services that were set in their final or most recent

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[48] In 2016, the Monitor's Second Report found the State of Delaware in compliance with the stipulations for the consent decree across all requirements including benchmarks in the provision of ACT, vouchers/subsidies/bridge funding, supported employment, and family or peer-support services. Unless otherwise specified, data is reflected from the final progress report from the Court Monitor prior to dismissal: Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: U.S. v. State of Delaware (9/9/16). U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0015.pdf

[49] The United States of America vs State of Delaware was dismissed on October 11th, 2016. Case ID: PB-DE-0003. Delaware Settlement Agreement Dismissal Fact Sheet. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0018.pdf

[50] New Hampshire Community Mental Health Agreement (CMHA) Expert Reviewer Report Number Seven (January 10, 2018). Retrieved from cmha-report-011018.pdf

[51] Kinsley, M.B. (2017). Report of the independent reviewer. In The Matter Of United States of America v. The State of North Carolina, Case 5:12-cv-00557-F. See Attachment A: Compliance Chart. Retrieved from http://www.disabilityrightsnc.org/sites/default/files/2017%20Attachment%20A%20Compliance%20Chart%20TCLI.pdf

[52] Cuddeback, G.S., Morrissey, J.P., & Meyer, P.S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803-1806.

[53] In 2016, the Monitor's Second Report found the State of Delaware in compliance with the stipulations for the consent decree across all requirements including benchmarks in the provision of ACT, vouchers/subsidies/bridge funding, supported employment, and family or peer-support services. Unless otherwise specified, data is reflected from the final progress report from the Court Monitor prior to dismissal: Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: U.S. v. State of Delaware (9/9/16). U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0015.pdf

[54] The United States of America vs State of Delaware was dismissed on October 11th, 2016. Case ID: PB-DE-0003. Delaware Settlement Agreement Dismissal Fact Sheet. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0018.pdf

reporting years. New Hampshire recently served nearly 1,000 consumers, and had developed capacity to serve 1,242. However, New Hampshire has not yet achieved its ACT capacity goal of 1,500 consumers per year.

Supported Housing Services

The agreement calls for Maricopa County to further expand supported housing services to an additional 300 members above the FY 2016 target goal of 1,200 members, for a total of 1,500 members served in FY 2017. Maricopa County exceeded the 2017 target goal for supported housing services in both FY 2016 (1,550) and FY 2017 (2,098).

Between 2013 and 2016 (the last year of the agreement), Delaware exceeded compliance standards for the number of consumers served with supportive housing funding and was determined to be in compliance with the final year stipulation to serve all consumers in need of supportive housing services, including those with the greatest need (those on the state's waiting list for supportive housing [48], the number of homeless individuals with SMI [132], and the number of individuals at the local mental health authority who are in inpatient care without a stable living situation at discharge [52]). In total, Delaware provided supportive housing services to 812 consumers, exceeding the previous 2015 stipulation target of 650 consumers. New Hampshire was slated to provide supported housing services to 600 consumers, but fell short of the target goal, as they served only 567 consumers. Similarly, North Carolina was stipulated to serve 1,624 consumers in 2017 and fell short by only serving only 1,159.

Supported Employment Services

In FY 2017, Maricopa County was required to expand supported employment services by an additional 500 members above the FY 2016 target goal of 750, for a total of 1,250 members served. In 2017, Maricopa County provided 8,168 consumers with supported employment services. Of those consumers, 1,708 received ongoing support, which is more consistent with high-fidelity supported employment, and that 1,708 figure significantly exceeded the target goal of 1,250.

In comparison, Delaware's served approximately 3,500 consumers with supported employment services according to the final agreement report (2016). Delaware's FY 2016 service expansion agreement stipulated that all ACT members (1,700 consumers), be served by employment services specialists. Not only did Delaware exceed the absolute numbers of individuals served with supported employment, but they also demonstrated about a fourfold increase in the proportion of supported employment members reaching employment (2013: 3.8% of supported employment members; 2016: 15.5% of supported employment members).[55] Similarly, New Hampshire far exceeded their consent decree's penetration target goal of 18.6% and achieved a 26.4% penetration rate in 2016. North Carolina was deemed to have only met "partial compliance" with its 2017 service goal of 1,624 consumers, as only 1,119 consumers received supported employment services.

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[55] Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: U.S. v. State of Delaware (9/9/16). U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0015.pdf

Peer Support Services and Family Support Services

Maricopa County's' agreement calls for 1,500 members to receive peer and family support services. In 2017, Maricopa County served over 12,000 people through peer and family support services, vastly exceeding the goal.

New Hampshire's agreement does not specify how much peer and family support services capacity will be added, and North Carolina does not explicitly identify and include peer and family support services for service expansion. Delaware committed to serving 1,000 people through peer support, and like Maricopa County, Delaware significantly exceeded their compliance goals for peer and family support services.

Overall Compliance Ratings

Based on the comparative analysis, Maricopa County's plan for expanded services appears to be in many ways similar to the selected states reviewed, although not all states included each of the services in Arizona's agreement, or included targets/goals for each service.

The table below provides a summary of each state's levels of compliance with agreements to expand services. The compliance status ratings below are based on the degree to which a state achieved their most recent service expansion benchmarks. When a state met its service expansion goal, it was considered to be "compliant." When a state far exceeded its expansion goal, the compliance status was considered to be "substantially compliant." Conversely, when a state failed to fully meet service expansion benchmarks, the state was deemed to be "partially compliant."

STATE	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT	PEER AND FAMILY SUPPORT SERVICES
Arizona	Substantially Compliant	Substantially Compliant	Substantially Compliant	Substantially Compliant
Delaware	Substantially Compliant	Compliant	Substantially Compliant	Substantially Compliant
New Hampshire	Partially Compliant	Partially Compliant	Substantially Compliant	Compliant
North Carolina	Substantially Compliant	Partially Compliant	Partially Compliant	Not Stipulated

Detailed Compliance Findings

The tables below summarize detailed findings for each state, by EBP or service type.

STATE	ENROLL MENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT (SE)	PEER AND FAMILY SUPPORT SERVICES
Arizona						
		FY 2015 and FY 2016	8 teams (some specialty)	Services for 1,200 class members	Services for 750 class members	Services for 1,500 class members
		FY 2017	13 teams (some specialty)	Services for 1,500 class members	Services for 1,250 class members	Services for 1,500 class members
2017 Update	31,712		21 ACT teams serve 1,962 consumers, and three FACT teams serve 271 consumers, 2,233 consumers received ACT/FACT	In 2017, 2,098 consumers received supported housing Maricopa County	In 2017, Maricopa County served 8,168 consumers with any degree of SE services. Of those consumers 1,708 received "on-going" SE, which is more likely to be consistent with high SE fidelity.	In 2017, 12,457 consumers in Maricopa County received peer and family support services.
Compliance Status			**Substantially Compliant**	**Substantially Compliant**	**Substantially Compliant**	**Substantially Compliant**

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT (SE)	PEER & FAMILY SUPPORT
Delaware						
		FY 2011	No Stipulation	Provision of vouchers/subsidies/bridge funding to 150 individuals	No Stipulation	No Stipulation
		FY 2012	Add 8 teams	Provision of vouchers/subsidies/bridge funding to 250 individuals	Provid SE to 100 individuals[56]	Provide family or peer support to 250 individuals
		FY 2013	Add 1 additional team	Provision of vouchers/subsidies/bridge funding to 450 individuals	Provid SE to 300 individuals	Provide family or peer support to 500 individuals
		FY 2014	Add 1 additional team	Provision of vouchers/subsidies/bridge funding to 550 individuals	Provid SE to 600 individuals	Provide family or peer support to 750 individuals
		FY 2015	Add 1 additional team	Provision of vouchers/subsidies/bridge funding to 650 individuals	Provid SE to 700 individuals	Provide family or peer support to 1,000 individuals
		FY 2016	No Stipulation	Provision of vouchers/subsidies/bridge funding to anyone in the target population who needs this support	Every consumer on ACT teams receives services from an employment specialist.	No FY 2016 Stipulation

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[56] The consent degree stipulated that beginning in 2012, all ACT recipients receive support from an employment specialist on their ACT team.

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT (SE)	PEER & FAMILY SUPPORT
Delaware						
Last Year of Consent Decree: 2016[57,58]	6,374[59]		15 ACT teams in operation, serving approximately 1,700 consumers[60]	812 consumers served in FY16 with vouchers/subsidies/bridge funding	Approximately 3,500 consumers served	Approximately 2,400 consumers served
Compliance Status			**Substantially Compliant**	**Compliant**	**Substantially Compliant**	**Substantially Compliant**

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[57] In 2016, the Monitor's Second Report found the State of Delaware in compliance with the stipulations for the consent decree across all requirements including benchmarks in the provision of ACT, vouchers/subsidies/bridge funding, supported employment, and family or peer-support services. Unless otherwise specified, data is reflected from the final progress report from the Court Monitor prior to dismissal: Tenth Report of the Court Monitor on Progress Towards Compliance with the Agreement: U.S. v. State of Delaware (9/9/16). U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0015.pdf

[58] The United States of America vs State of Delaware was dismissed on October 11th, 2016. Case ID: PB-DE-0003. Delaware Settlement Agreement Dismissal Fact Sheet. Retrieved from https://www.clearinghouse.net/chDocs/public/PB-DE-0003-0018.pdf

[59] Number served by the state mental health authority living with an SMI as reported in the Delaware 2016 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System report.

[60] In additional to ACT teams, the State of Delaware funds intensive case management teams and Community Re-Integration support program teams.

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT	PEER AND FAMILY SUPPORT SERVICES
New Hampshire						
		June 2014	Each mental health region has an ACT team	Serve 240 consumers	Increase penetration rate by 2% over 2012 penetration rate of 12.1% to 14.1%	Maintain family and peer support services consistent with the agreement[61]
		October 2014	All 11 ACT teams operate within the standards of the settlement	Serve an additional 50 consumers, for a total of 290	All individuals receiving ACT will have access to supported employment from an employment specialist on their ACT team	
		June 2015	Serve at least 1,300 of the target population	Serve an additional 50 consumers, for a total of 340	Increase penetration rate by 2% to 16.1%	
		June 2016	Serve an additional 200 people, for capacity up to 1,500	Serve an additional 110 consumers, for a total of 450	Increase penetration rate by 2% to 18.1%	

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[61] The State of New Hampshire must maintain a system of family and peer support services offered through peer support centers which each maintian a minimum of 44 operating hours per week.

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT	PEER AND FAMILY SUPPORT SERVICES
New Hampshire						
		June 2017	Maintain capacity for 1,500 consumers and a registry of consumers at-risk for inpatient admission[62]	Additional 150 for a total of 600	Increase penetration rate by 5% to 18.6%; Maintain a list of individuals with SMI who would benefit from supported employment services but for whom it is not available	
Updated 2018[63]	12,014[64]		Currently serving 992 consumers with capacity to serve 1,242	As of September 2017, there are 567 people in leases or approved for bridge subsidy housing	Currently, 3,525 served out of 13,375 eligible consumers; Penetration rate equals 26.4%[65]	2,685 served across 15 contracted peer support agency program sites

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[62] Consent decree stipulates that "the State, through its community mental health providers, will identify and maintain a list of all individuals admitted to, or at risk serious risk of being admitted to, NHH and/or Glencliff for whom ACT services are needed but not available, and develop effective regional and statewide plans for providing sufficient ACT services to ensure reasonable access by eligible individuals in the future." Retrieved from https://www.dhhs.nh.gov/dcbcs/bbh/documents/cmha-report-011018.pdf

[63] New Hampshire Community Mental Health Agreement (CMHA) Expert Reviewer Report Number Seven (January 10, 2018). Retrieved from cmha-report-011018.pdf

[64] Number served by the state mental health authority living with an SMI as reported in the New Hampshire 2016 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System report.

[65] Per the CMHA, the State of New Hampshire must demonstrate that they "1) provide SE services in the amount, duration, and intensity to allow individuals the opportunity to work the maximum number of hours in integrated community settings consistent with their individual treatment plans (V.F.1); 2) meet Dartmouth fidelity standards for supported employment; and 3) meet penetration rate mandates set out in the CMHA."

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT	PEER AND FAMILY SUPPORT SERVICES
New Hampshire						
Compliance Status			Partially Compliant	Partially Compliant	Substantially Compliant	Substantially Compliant

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT	PEER AND FAMILY SUPPORT SERVICES
North Carolina						
		July 2013	Increase to 33 teams serving 3,225 individuals	Increase housing slots 100 to 300	Serve 100 consumers	No Stipulation
		July 2014	Increase to 34 teams serving 3,467 individuals	Increase housing slots 250 to 450	Serve 250 consumers	
		July 2015	Increase to 37 teams serving 3,727 individuals	At least 708 housing slots	Serve 708 consumers	
		July 2016	Increase to 40 teams with capacity to serve 4,006	At least 1,166 housing slots	Serve 1,166 consumers	
		July 2017	Increase to 43 teams with capacity to serve 4,307	Serve 1,624 consumers	Serve 1,624 consumers	

STATE	ENROLLMENT	TIMELINES	ACT	SUPPORTED HOUSING	SUPPORTED EMPLOYMENT	PEER AND FAMILY SUPPORT SERVICES		
Updated 2018[66]	83,285[67]		72 teams serving 6,842 people[68]	Served 1,159 consumers	Served 1,119 consumers			
Compliance Status			**Substantially Compliant**	**Partially Compliant**	**Partially Compliant**	**Not Stipulated**		

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[66] Kinsley, M.B. (2017). Report of the independent reviewer. In The Matter Of United States of America v. The State of North Carolina, Case 5:12-cv-00557-F. See Attachment A: Compliance Chart. Retrieved from http://www.disabilityrightsnc.org/sites/default/files/2017%20Attachment%20A%20Compliance%20Chart%20TCLI.pdf

[67] Number served by the state mental health authority living with an SMI as reported in the North Carolina 2016 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System report.

[68] The total number served in the most recent fiscal year was not updated in the most recent compliance report. According to the North Carolina 2016 Mental Health National Outcome Measures (NOMS): SAMHSA Uniform Reporting System, the state mental health authority served 6,842 consumers with ACT.

CONSUMER OPERATED SERVICES

Multi-Evaluation Component Analysis

Service Descriptions:

Peer support services are delivered in individual and group settings by individuals who have personal experience with mental illness, substance abuse, or dependence, and recovery to help people develop skills to aid in their recovery.

Family support services are delivered in individual and group settings and are designed to teach families skills and strategies for better supporting their family member's treatment and recovery in the community. Supports include training on identifying a crisis and connecting recipients in crisis to services, as well as education about mental illness and about available ongoing community-based services.

Focus Groups

As part of the service capacity assessment of the four priority behavioral health services in Maricopa County, four focus groups were conducted with key system stakeholders. The focus groups were developed to facilitate discussion with participants with direct experience with the four priority mental health services. Key findings derived from the focus groups regarding the delivery system's capacity to deliver peer support and family support services included:

- Focus group participants reported that family support specialists may now receive a specialized certification to provide family support services. This is separate from the existing Peer Support Specialist Certification and permits family support specialists/mentors to bill under a certified position. Family mentors stated they were pleased to see this certification become available as participants felt that it adds credibility to the position and creates a sense that the family mentors are genuine members of the clinical team.
- Focus group participants shared that some PNOs are increasing the number of peers that are employed as "peer navigators." The peer navigator is a relatively new position and is described as a peer that participates on the clinical team, is trained as a case manager and carries a caseload of assigned members. These individuals may also facilitate clinic-based peer support groups. Focus group participants reported that the peer navigators can, at times, become overwhelmed with the extent and scope of assigned tasks.
- Similar to last year, participants reported that not every direct care clinic employs a peer support specialist or family support specialist. Staff turnover remains high and vacancies may not be immediately filled. Participants also felt that during times of budget reductions, the family support specialist positions are often the first to be eliminated.
- As reported in prior year service capacity assessments, participants in all focus groups expressed that clinical teams do not consistently demonstrate an understanding of the appropriate role of the peer support specialist, peer or recovery navigator and/or family support specialist. This lack of clarity has led to confusion regarding how to best utilize these resources. In particular, many family member focus group attendees reported that they were not aware of the availability of peer support or family support specialists or how to access them if needed.

CONSUMER OPERATED SERVICES

- Peer and family support specialists report that they are often overwhelmed by the assigned member case load size and work demands. Caseloads were reported to range from 1,400 to 2,000 members. Focus group participants stated that peer and family support specialists need more job supports to be successful in their roles.
- Family members stated that it would be helpful to have family support specialists/mentors available at hospitals to support families during a mental health crisis. Likewise, case manager participants expressed that it would also be beneficial to introduce family members to family support specialists/mentors at the onset of care to establish rapport and help family members to understand their role on the clinical team.
- Family members and case manager focus group participants reported a need for increased after-hour availability of family support specialists.
- Participants in all focus groups expressed a need for more diversity in ethnicity and race among peer support specialists. Culturally, it can be challenging to match members with peer support specialists who are not similar to them in ethnicity and/or race. Differing genders can also pose a challenge for members of certain cultural backgrounds. Similarly, participants recommended hiring peers who have specialized skills in substance use disorders, particularly opioid use, who can work effectively with members with these challenges.
- Participants in the provider focus group reported that it can be challenging to find and retain skilled peer support specialists. Due to the requirements of the job, peer support specialists must pass fingerprint clearance reviews, possess strong computer skills and have access to reliable transportation. These requirements, attributes and resources can be challenging for peer support specialists to achieve.
- Similar to the past two years, family members, individuals receiving services and case managers all agree that family members would benefit from a service delivery system navigational guide and/or a compendium of available supports and resources that can be accessed.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding availability, quality, and access to the priority services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. It should be noted that the survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

Most survey respondents felt that peer support services were easy to access (83%). 8% of survey respondents indicated that peer support services were difficult to access and none of the respondents believed that the services were inaccessible. Consistent with the last four years, peer support services were perceived as the easiest of all the priority services to access.

CONSUMER OPERATED SERVICES

5% of survey respondents felt that family support services were difficult to access while 64% of the respondents indicated that family support services were easy to access. The remaining 31% of respondents rated access to family support services as "fair".

Overall, perceptions regarding the ease of accessing peer support services remained generally consistent during CY 2017 when compared to CY 2016 results.

Easy ability to access services
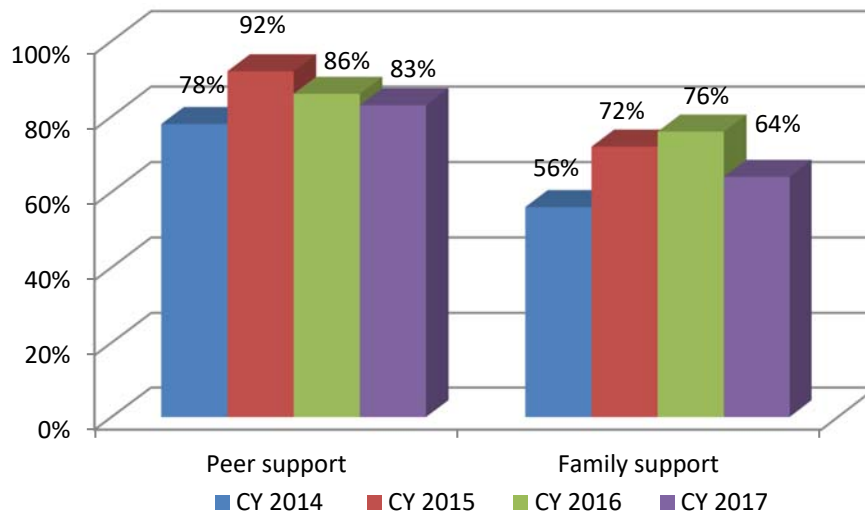
The most common factors identified that negatively impact accessing peer support services were:
- Member declines service
- Clinical team unable to engage/contact member
- Transportation barriers
- Staffing turnover

CONSUMER OPERATED SERVICES

The most common factors identified that negatively impact accessing family support services were:
- Clinical team unable to engage/contact member
- Member declines services
- Transportation barriers

In terms of service utilization, 95% of the responses indicated that peer support services were being utilized efficiently or were utilized efficiently most of the time. 5% of respondents indicated that the peer support services were not utilized efficiently.

78% of the responses indicated that family support services were being utilized effectively or were utilized efficiently most of the time. Alternatively, 22% of the responses indicated that family support services were not utilized efficiently.

Regarding the duration of time to access peer support services and family support services after a need has been identified:
- 94% of the survey respondents reported that peer support services could be **accessed within 30 days** of the identification of the service need. This finding compares to 75% during CY 2014, 78% during CY 2015 and 82% during CY 2016.
- 80% of the survey respondents reported that family support services could be **accessed within 30 days** of the identification of service need. This finding compares to 33% during CY 2013, 69% during CY 2014, 74% during CY 2015 and 79% during CY 2016.
- 0% reported it taking **four to six weeks to access** peer support services following the identification of need (20% – CY 2013; 13% – CY 2014; 15% - CY 2015; 13% - CY 2016).
- 13% percent reported it taking **four to six weeks to access** family support services following the identification of need (44% – CY 2013; 8% – CY 2014; 13% - CY 2015; 13% - CY 2016).
- 6% of the survey respondents reported that it would take an average **of six weeks or longer to access** peer support services (10% – CY 2013; 13% – CY 2014; 7% - CY 2015; 4% - CY 2016).
- 7% of the survey respondents reported that it would take an average **of six weeks or longer to access** family support services (22% – CY 2013; 23% – CY 2014; 13% - CY 2015; 8% - CY 2016).

Medical Record Reviews Group 1

A random sample of 121 recipients was identified to support an analysis of assessment and service planning documentation. The review evaluated the extent to which the clinical teams were identifying needs for peer support services and family support services. When identified as needed service to benefit the recipient, information was reviewed to determine if the need was translated to the recipient's ISP and identified as a specific intervention. The entire sample of recipients was subsequently interviewed to collect information regarding their perceived needs for the same services.

CONSUMER OPERATED SERVICES

As noted in previous service capacity assessments, medical record documentation revealed that the clinical teams are regularly assessing the recipient's need and desire for social and community integration. This establishes the ability to identify opportunities to apply targeted interventions to address related needs, such as peer support services.

26% of the Group 1 assessments identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 71% of the time.

36% of the Group 1 recipients received at least one unit of peer support services during CY 2017 based on a review of service utilization data.

Interviews
All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview asked the following:
*   Did the clinical team assess the recipient's need for peer support services? 45% of the respondents indicated that the clinical team had discussed peer support service opportunities.
*   Is the clinical team's assessment consistent with the recipient's perception regarding the need for one or more of the priority mental health services? In slightly over half of the cases (51%), the clinical team's determination of need matched the recipient's perception of need.

Assessment of need for peer support

Legend: CY 2014, CY 2015, CY 2016, CY 2017
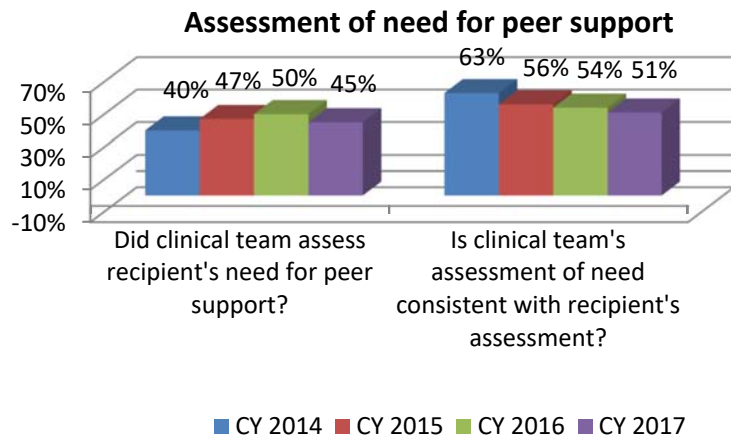
CONSUMER OPERATED SERVICES

Family Support Services

For most of the assessments reviewed, the clinical teams identify and document natural and family supports that are important to the member. Most of the records reviewed included evidence that family supports were at least identified by the clinical team. Family support services can be an effective intervention for family members to develop skills to interact and support the person in the home and community. Despite the clinical team's identification of natural and family supports, ISPs rarely included family support services.

Consistent with findings during CY 2013, CY 2014, CY 2015 and CY 2016, opportunities continue to exist to leverage family support services to support family members in working with recipients to achieve their ISP goals.

4% of the assessments reviewed identified a related need for family support services. In these cases, none of the ISPs identified family support services as an intervention to address the need.

2% of the Group 1 recipients received at least one unit of family support services during CY 2017 based on a review of service utilization data.
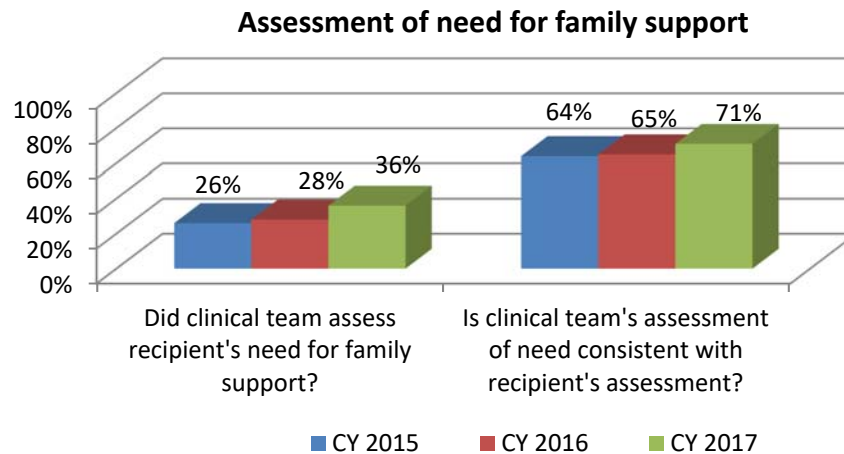
Interviews

All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview asked the following:
- Did the clinical team assess the recipient's and family's need for family support services? 36% of Group 1 recipients recalled discussing family support services with the clinical team.
- The clinical team's assessment was found to be consistent with the recipient's perception regarding the need for family support services in 71% of the cases.

CONSUMER OPERATED SERVICES

Assessment of need for family support

Chart data:

	Did clinical team assess recipient's need for family support?	Is clinical team's assessment of need consistent with recipient's assessment?
CY 2015	26%	64%
CY 2016	28%	65%
CY 2017	36%	71%

Medical Record Reviews: Group 2

A random sample of 199 SMI recipients' medical record documentation was reviewed to assess the consistency in which peer support services and family support services were assessed by the clinical team, identified as a needed service to support the recipient, and included as part of the ISP.

59% of the ISPs included peer support services when assessed as a need.

49% of the recipients included in the sample received at least one unit of peer support during CY 2017 based on a review of service utilization data.

CONSUMER OPERATED SERVICES

Peer support services
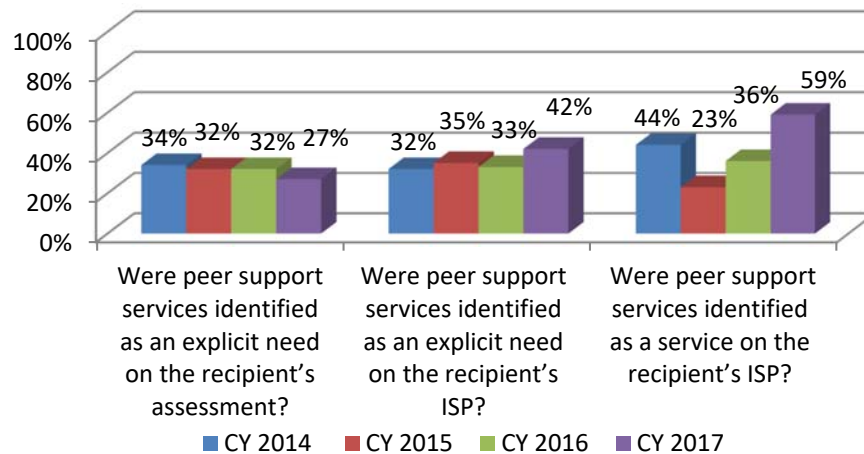
Reviewers were able to review progress notes and record the documented reasons that the person was unable to access peer support services when recommended by the clinical team. The most common findings included the following:
- The clinical team did not follow up with initiating a referral for the service; and
- The member declined to attend the service.

Family Support Services
As part of the clinical services assessment process, information is routinely collected and documented by the clinical team regarding the natural and family supports available and important to the recipient.

19% of the ISPs included family support services when identified as a need as part of the recipient's assessment and/or ISP.

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2% of the recipients included in the sample received at least one unit of family support during CY 2017 based on a review of service utilization data.

Family support services

Legend: ■ CY 2014 ■ CY 2015 ■ CY 2016 ■ CY 2017
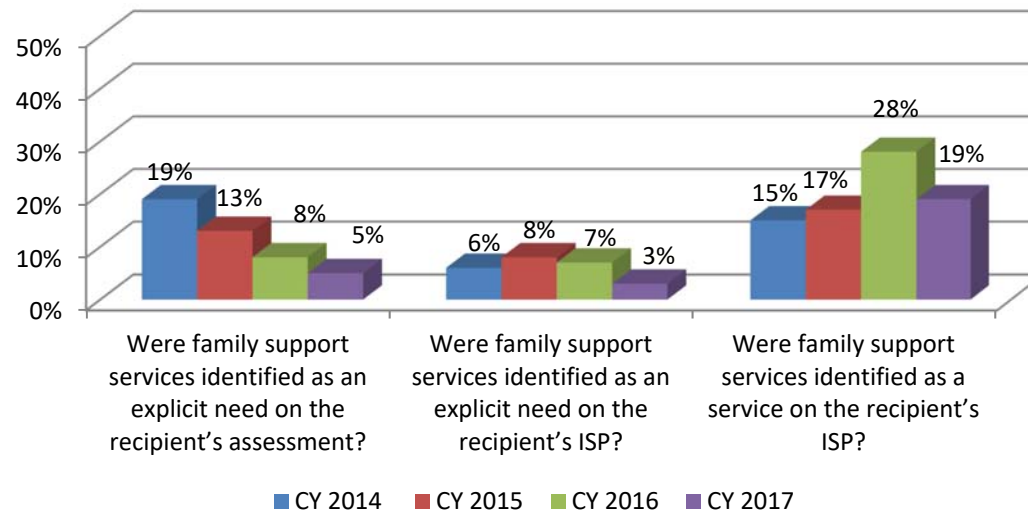
- In 9 cases, the person was unable to access family support services after the service was recommended by the clinical team. Reviewers were able to review progress notes and determined that in 44% of these cases, there was no documentation that the clinical team initiated a referral for the service.

The Mercer review team noted that much of the language used in the assessments and individual service plans was not recovery oriented; and that the clinical teams did not distinguish between a recovery model and a medical model of behavioral health service delivery. Much of the language in the records appeared to be driven by the templates used for the assessments and the individual service plans. It was noted that there was very little evidence that peer support services included an exploration and identification of the member's individual recovery goals, the acquisition of knowledge and resources by the member to acquire a sense of self-efficacy in pursuing their recovery process, or that the clinical team viewed the members as equal partners in their recovery journey.

Additionally, the Mercer team regularly identified the misapplication of priority mental health services by the member's assigned clinical team. In one example, the clinical team documented the member's identified need for social/community integration with the following specific objective: "member needs to continue to visit with family and friends". The corresponding service category and service to address the member's need and objective was "family support" with service code "S5110" listed.

CONSUMER OPERATED SERVICES

The *AHCCCS Behavioral Health Covered Services Guide* defines family support as *Home care training family services (family support) with family member(s) directed to restoration, enhancement, or maintenance of the family functioning to increase the family's ability to effectively interact and care for the person in the home and community. May involve support activities such as assisting the family to adjust to the person's disability, developing skills to effectively interact and/or guide the person, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the person and the family.*

The most prominent misunderstanding illustrated by this example is that family support is an intervention *directed to and performed with the member's family member(s)* with the goal of promoting the family's ability to effectively interact and support the member.

Service Utilization Data

During the time period of October 1, 2016 through June 30, 2017, 30,554 unique users were represented in the service utilization data file. Of those, 81% were Medicaid eligible and 19% were non-Title XIX eligible.

- Overall, 37% of the recipients received at least one unit of peer support services during the time period (33% over a comparable time period last year).

Access to the service was similar between Title XIX (38%) and non-Title XIX groups (34%).

An analysis of the persistence in peer support services was completed by analyzing the sustainability of engagement in the service over consecutive monthly intervals.

- Slightly less than half of the members who received at least one unit of peer support during the review period accessed the service during a single month.
- Nearly 70% of all members who received at least one unit of peer support during the review period accessed the service for one or two months.

CONSUMER OPERATED SERVICES

PERSISTENCE IN PEER SUPPORT SERVICES OCTOBER 2016 — JUNE 2017			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	47.7%	57.1%	49.3%
2	19.6%	18.8%	19.5%
3–4	17.3%	13.0%	16.6%
5–6	7.4%	4.9%	7.0%
7–8	3.3%	1.7%	3.0%
9	4.5%	4.1%	4.4%

Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.

Family support services (i.e., Home Care Training Family) are assigned a unique service code (S5110). The billing unit is 15 minutes in duration.
- Overall, 2.0% of the recipients received at least one unit of family support services during the time period (2.1% over a comparable time period last year).

Access to the service was split between Title XIX (2.0%) and non-Title XIX groups (2.0%).

An analysis of the persistence in family support services was completed by analyzing the sustainability of engagement in the service over consecutive monthly intervals.
- 80% of the members who received at least one unit of family support during the review period accessed the service during a single month, up from 77% last year.
- Over 90% of all members who received at least one unit of family support during the review period accessed the service for one or two months.

CONSUMER OPERATED SERVICES

PERSISTENCE IN FAMILY SUPPORT SERVICES OCTOBER 2016 — JUNE 2017			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	79.2%	83.8%	80.0%
2	11.9%	9.3%	11.4%
3–4	4.9%	3.3%	4.6%
5–6	2.1%	1.6%	2.0%
7–8	0.7%	0.8%	0.7%
9	0.9%	0.8%	0.9%

Recipients may be duplicated based on multiple consecutive month periods of service within the time frame.

Key Findings and Recommendations
Significant findings regarding the demand and provision of peer support and family support services are presented below.

Findings: Peer Support
- Service utilization data reveals a sustained level in the percentage of members who received at least one unit of peer support services during the review period. During CY 2017, 37% of members received peer support services representing the second highest percentage observed since CY 2013 and CY 2016. (CY 2013 — 38%; CY 2014 — 31%; CY 2015 — 29%; CY 2016 – 38%).
- Participants in all focus groups expressed that clinical teams do not consistently demonstrate an understanding of the appropriate role of the peer support specialist, peer or recovery navigator and/or family support specialist. This lack of clarity has led to confusion regarding how to best utilize these resources. In particular, many family member focus group attendees reported that they were not aware of the availability of peer support or family support specialists or how to access them if needed.
- Most survey respondents felt that peer support services were easy to access (83%). 8% of survey respondents indicated that peer support services were difficult to access and none of the respondents indicated that the services were inaccessible. Consistent with the last four years, peer support services were perceived as the easiest of all the priority services to access.

CONSUMER OPERATED SERVICES

- 26% of the Group 1 assessments identified peer support as a need. When assessed as a need, peer support services were identified on the recipient's ISP 71% of the time.
- Maricopa County excels in making peer support services available to persons in recovery. The penetration rates in 2016 and 2017 are relatively high and represent a best practice benchmark in terms of access to peer support services.
- Over 30% of all members who received at least one unit of peer support during the review period accessed the service for more than one or two consecutive months.
- The Mercer review team noted that much of the language used in the assessments and individual service plans was not recovery oriented; and that the clinical teams did not distinguish between a recovery model and a medical model of behavioral health service delivery. Much of the language in the records appeared to be driven by the templates used for the assessments and the individual service plans. It was noted that there was very little evidence that peer support services included an exploration and identification of the member's individual recovery goals, the acquisition of knowledge and resources by the member to acquire a sense of self-efficacy in pursuing their recovery process, or that the clinical team viewed the members as equal partners in their recovery journey.
- As reported by the Maricopa County RBHA, peer support and family support contracted capacity is capable of serving at least 2,215 members.

Findings: Family Support

- Service utilization data shows minor differences in the percentage of members who received at least one unit of family support services over the respective review periods (CY 2013 – 2%; CY 2014 – 3%; CY 2015 – 2%; CY 2016 – 2%; CY 2017 – 2%).
- For most of the assessments reviewed, the clinical teams identify and document natural and family supports that important to the member. Most of the records reviewed included evidence that family supports were identified by the clinical team. Family support services can be an effective intervention for family members to develop skills to interact and support the person in the home and community. Despite clinical team's identification of natural and family supports, individual service plans rarely included family support services.
- The clinical team's assessment was found to be consistent with the member's perception regarding the need for family support services in 71% of the cases reviewed.
- The Mercer team regularly identified the misapplication of priority mental health services by the member's clinical team, including family support. The most prominent misunderstanding is recognizing that family support is an intervention directed to and performed with the member's family member(s) with the goal of promoting the family's ability to effectively interact and support the member.

Recommendations: Peer Support

- Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including peer support.
- Perform initial and ongoing training to clinical team members to differentiate between a recovery model and a medical model of behavioral health service delivery, how to utilize a recovery oriented approach in interacting with members and how to apply recovery

oriented language in documenting the individual's recovery.

CONSUMER OPERATED SERVICES

- For those members who are less engaged with the clinical team, or who have made minimal progress with treatment goals in the preceding year; invite those members to work with a peer support specialist to develop a recovery plan that can inform the annual assessment and individual service planning process.

Recommendations: Family Support

- Ensure the consistent application of privacy practices at the direct care clinics to balance compliance with member confidentiality while providing opportunities for involved family members to participate in the member's care as appropriate and consistent with the member's choice.
- Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including family support.
- Provide additional training and supervision to recognize the value of family support services as effective service plan intervention.

SUPPORTED EMPLOYMENT

Service Description

Supported employment services are services through which recipients receive assistance in preparing for, identifying, attaining, and maintaining competitive employment. The services provided include job coaching, transportation, assistive technology, specialized job training and individually tailored supervision.

Focus Groups

Findings collected from focus group participants regarding supported employment services included the following themes:

- Similar to observations from last year, there has been a perceived increase in the number of Vocational Rehabilitation (VR) specialists co-located at the clinics. While there is noted variation in the timely access to VR services, participants expressed that the increased availability of VR specialists continues to be a positive change.
- Participants in the provider and case manager focus groups reported that the positive "philosophical shift" regarding employment continues to prevail. This has resulted in a perceived reduction in clinical teams simply assessing a member's readiness for employment to more substantive engagement with individuals regarding work interests, work history and conveying the inherent value that employment can bear for individuals advancing their personal recovery.
- Similar to last year, participants in the provider and case manager focus groups stated that members are encouraged to pursue a wider variety of employment opportunities outside of peer support specialist training and employment. Provider organizations are now co-located at the clinics leading to more diverse opportunities for members. Case manager participants also reported that they continue to observe an increase in the number of employers who are willing to hire individuals with SMI diagnoses.
- Participants in the consumer and family member focus groups reported varied success in obtaining employment as a result of encouragement from the clinics and the supported employment services provided by VR. One family member shared that her step-

son utilized VR services and now works as a part-time cashier. VR assisted with the development of a resume, job skill development, provided him with access to a computer and then assisted with searching and applying for jobs.

- Focus group participants reported that co-located employment specialists are no longer prevented from attending clinical team meetings. This has resulted in a perceived improvement in collaboration and communication with employment specialists, and in turn, smoother and faster employment referrals.
- Similar to last year, provider and case manager focus group participants report that benefit specialists are available in most clinics; however, the technical knowledge of the benefit specialists can vary. Not all are familiar with Disability101 training or do not appear able to explain the impact of employment on benefits. Participants in all four focus groups reported that some members and family members remain concerned about the potential loss of health and welfare benefits due to income generated from employment. One family member stated, "I'm still very scared about the impact of working on my son's benefits. It's my biggest fear."
- Many participants agreed case managers appear to have an increased understanding of programs such as "Freedom to Work," "Ticket to Work" and the availability of "Disability 101" trainings. Participants in the provider focus group reported that providers offer training to their employees to ensure that staff are knowledgeable about the impact of employment on benefits.

SUPPORTED EMPLOYMENT

- Participants in the case manager focus group reported that the clinics are no longer able to utilize taxis to transport members to and from work. This has become a barrier to maintaining employment for members who work during off shifts (e.g. closing or late night shifts) when public transportation is unavailable.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding the availability, quality and access to the priority mental health services, a key informant survey was administered. The survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

17% of survey respondents felt that supported employment services were difficult to access, comparable to last year (21%) and significantly less than CY 2013 and CY 2014 (75% – CY 2013; 33% – CY 2014). 83% of respondents indicated that supported employment services were easy to access or having "fair" access, an increase from CY 2016 (79%) and significantly higher than CY 2014 (66%).

Factors that negatively impact accessing supported employment services included:

- Member declines services;
- Clinical team unable to engage/contact member; and
- Transportation barriers.

78% of the responses indicated that supported employment services were being utilized efficiently or were utilized efficiently most of the time, up slightly from 77% last year. 22% of respondents indicated that supported employment services were not utilized efficiently.

79% of the survey respondents reported that supported employment services could be **accessed within 30 days** of the identification of the service need. This compares to 73% during CY 2016, 70% during CY 2015, 60% during CY 2014, and 22% during CY 2013. 5% of the survey respondents reported that it would take an average of **six weeks or longer** to access supported employment services.

Medical Record Reviews Group 1

The Group 1 medical record review sought to answer the following questions regarding the assessment process and determination that assessed needs were addressed as part of the recipient's ISP.
- Is there evidence that the need for supported employment services was assessed by the clinical team?
- When assessed as a need, are supported employment services identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for supported employment services?

SUPPORTED EMPLOYMENT

Findings specific to supported employment services are presented below.
- 28 of 121 (23%) Group 1 medical records identified an assessed need for supported employment services.
- When assessed as a need, 64% of the ISPs included a supported employment service.
- In 26 cases, the ISP included supported employment services despite an absence of any assessed need for the service.
- Several cases with an assessed need for supported employment services included evidence that the clinical team lacked awareness of the appropriate application of covered behavioral health services when identifying services on a member's ISP.
- 27% of the Group 1 recipients received at least one unit of supported employment services during CY 2017.

Interviews
The member interviews revealed the following findings:
- Less than half (45%) of the interview respondents reported that there was an assessment regarding supported employment needs and available services, the same finding as CY 2016.
- In 55% of the cases, the clinical team's assessment of need for supported employment services was consistent with the recipient's perception of need.

Medical Record Reviews: Group 2

The results of the medical record review for Group 2 showed that supported employment services were identified as a need on either the recipient's assessment and/or ISP in 59% of the cases reviewed. Supported employment services were identified as a service on the recipient's ISP in 82% of the cases reviewed when assessed as a need. (CY 2013 – 13%; CY 2014 – 26%; CY 2015 – 22%; CY 2016 – 53%).

35% of the recipients included in the sample received at least one unit of supported employment during CY 2017 based on a review of the service utilization data.

In 77 cases, reviewers were able to review progress notes and record the reasons that the person did not access supported employment services after a supported employment need was identified by the clinical team. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 40% of those cases in which the person did not access the service despite an identified need – the same result identified during CY 2016.

In some medical records reviewed, it was noted that the clinical team identified services on the member's individual service plan in the absence of, or even contrary to, the member's assessed needs. In one case, the member reported that she was "unable to work at this time due to symptoms". In response to the member's statement, the clinical team documented as part of the assessment that the member needed to "develop coping skills". The member's individual service plan included the same assessed need ("develop coping skills") with a corresponding service of psychoeducation support employment services [and included billing codes H2025 (ongoing support to maintain employment) and H2027 (pre-job training and development)].

SUPPORTED EMPLOYMENT

Some assessments lack internal consistency and include contradictory statements. For example, Mercer reviewed a member's assessment and noted the following statement in reference to the member: "Not currently employed and not interested in employment at this time". In another section of the same assessment in response to the following template prompt: "List any new goals for the service plan", the clinical team documented the following statement attributed to the member: "I want to get a job where I can work alone". In this case, the corresponding individual service plan did not include a supported employment goal, objective or service.

In another set of examples, an ISP objective that was included for several members assigned to the same PNO/clinic oversight entity read: "Rehab Specialist: Rehab Specialist services may include assessment of level of assistance he/she requires to create, plan and successfully work towards accomplishing his/her employment/learning and social engagement goals." The services identified to support this objective include H2027 (pre-job training and development) and H2025 (ongoing support to maintain employment). The objective and corresponding supported employment services appeared verbatim on several member's individual service plans and, in some cases, did not align with the member's corresponding assessment (e.g., was included in the individual service plan of a 79 year-old retired woman with significant medical conditions that limit her capacity to be in the community).

These examples reveal several issues that warrant further review by entities involved in the system of care:
- Assessed needs and corresponding individual service plan interventions are commonly misaligned and suggest that some clinical teams responsible for developing the service plan in coordination with the member do not fully understand the appropriate application of the priority mental health services, including supported employment.
- Individual service plans are not always based on the member's assessed needs and can include generic language that does not differentiate each member's unique circumstances and needs.

- The most prevalent reason noted by Mercer's review team for why members don't access services identified on the individual service plan is that there is a lack of documentation that the clinical team followed up with referring and coordinating access to the service. However, if the services identified on the individual service plan are not based on the member's assessed needs as illustrated by these examples, the member may have never required the service in the first place.
- The RBHA has designed and implemented a provider monitoring medical review tool that assesses if the member's service plan contains services based on the needs of the individual and reportedly shares audit findings with the adult PNOs and administrative entities. Despite these RBHA monitoring efforts, Mercer's medical record review findings suggest that significant provider performance deficiencies persist in this area based on the review of a random sample of medical records.

Service Utilization Data
Three distinct billing codes are available to reflect the provision of supported employment services. Billing code distinctions include:
- Pre-job training and development (H2027)
- Ongoing support to maintain employment:
  – Service duration 15 minutes (H2025)
  – Service duration per diem (H2026)
  –

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H2027 — Psychoeducational Services (Pre-Job Training and Development)
Services which prepare a person to engage in meaningful work-related activities may include but are not limited to the following: career/educational counseling, job shadowing, job training, including Work Adjustment Training (WAT); assistance in the use of educational resources necessary to obtain employment; attendance to RSA/VR Information Sessions; attendance to Job Fairs; training in resume preparation, job interview skills, study skills, budgeting skills (when it pertains to employment), work activities, professional decorum , time management, and assistance in finding employment.

H2025 — Ongoing Support to Maintain Employment
Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.

H2026 — Ongoing Support to Maintain Employment (per diem)
Includes support services that enable a person to maintain employment. Services may include monitoring and supervision, assistance in performing job tasks, and supportive counseling.
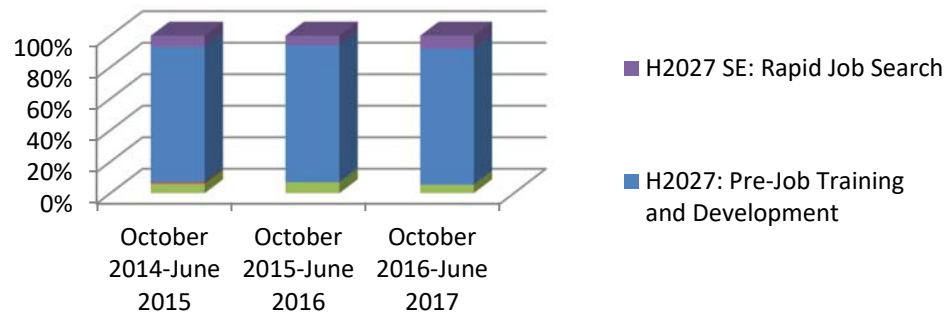
For the time period October 1, 2016 through June 30, 2017, H2027 (pre-job training and development) accounts for 94% of the total supported employment services (an increase from CY 2015 – 84% and CY 2016 – 87%). H2025 (ongoing support to maintain employment/15 minute billing unit) represents 6% of the supported employment utilization (CY 2013 – 7%; CY 2014 – 6%; CY 2015 – 9%; CY 2016 – 7%). H2026 (ongoing support to maintain employment/per diem billing unit) accounted for less than 1% of the overall supported employment utilization.

A billing modifier (i.e., SE) is applied in conjunction with billing code H2027. Mercer analyzed the presence of this code and modifier within the service utilization data file (see graphic below). H2027 SE represents 9% (CY 2016 - 6%) of the overall supported employment utilization. The intended use of the modifier is to track members who are engaged in rapid job search with an expected outcome of securing employment within 45 days of engaging in supported employment services.

During interviews with key informants, including supported employment providers, one challenge related to providing ongoing support to maintain employment (H2025) was that billing procedures prohibited the application of the service telephonically. Once a member is employed, it can be challenging to periodically meet in-person with supported employment job coaches or others that may be providing ongoing support to help the person maintain employment. Beginning in July 2017, the *AHCCCS Covered Behavioral Health Services Guide* was revised to allow H2025 to be encountered with place of service code (POS) 02 and be conducted with the member telephonically. Data acquired from the Maricopa County RBHA demonstrated that 53 unduplicated members during July – September 2017 and 125 unduplicated members during October – December 2017 were affiliated with telephonic ongoing support to maintain employment services.

SUPPORTED EMPLOYMENT

Supported Employment service encounters

Legend: H2027 SE: Rapid Job Search; H2027: Pre-Job Training and Development. X-axis categories: October 2014-June 2015, October 2015-June 2016, October 2016-June 2017.

Information was collected during key informant interviews with key system stakeholders, including RBHA contracted supported employment providers. To increase access to supported employment services, supported employment providers, the Maricopa County RBHA and the PNOs/administrative entities have partnered to co-locate supported employment specialists/job developers in many of the direct care clinics. Per one supported employment provider, supported employment specialists are available at 11 different direct care clinics with a targeted member case load of 25 members or less. The agency's supported employment specialists spend all work hours at the assigned clinic and are provided work spaces alongside the direct care clinical teams. The clinical teams and the supported

employment specialists meet regularly to integrate and coordinate services for members interested in obtaining and/or maintaining employment. The meetings provide a forum for the supported employment specialist to share the current caseload of members engaged in supported employment services, support outreach efforts and to review the member's clinical status.

Most supported employment service referrals are initiated by the direct care clinical teams via a rehabilitation specialist; a required staffing position in the RBHAs' contracts with the adult PNOs and Administrative Entities that operate and manage the direct care clinics.[69] Mercer obtained varied information regarding the intended roles and responsibilities of the rehabilitation specialist. During one interview with a supported employment provider, it was reported that the rehabilitation specialists do not have an assigned case load of members if part of a connective or supportive level of case management, and are not intended to provide direct supported employment services to members. However, another system stakeholder reported that the rehabilitation specialists can provide direct supported employment services depending on the member's individual circumstances, but should not be engaged in case management activities.

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Per the RBHA, the primary role of the rehabilitation specialists are to assess members' needs to get involved in vocational rehabilitation or employment services, but should not be providing direct pre-job training and development services (i.e., H2027).[70] Mercer confirmed that rehabilitation specialists are documenting progress notes with supported employment bill codes (i.e., H2027) through the medical record reviews of a sample of SMI members, but also noted that rehabilitation specialists were regularly billing case management activities as well.

The rehabilitation specialist was described as the "hub" for a member's employment pursuit, working to coordinate referrals to supported employment providers and other vocational rehabilitation resources. Several sources reported that rehabilitation specialist staffing vacancies are widespread and therefore are not consistently available to the clinical teams, compromising efforts to link members to supported employment services. The RBHA acknowledged that "identified areas of concern" have been noted with rehabilitation staffing vacancies and are currently following up with the Adult PNOs and administrative entities to gather additional information and may consider initiating contract enforcement actions with select PNOs and/or administrative entities.

The supported employment specialists and rehabilitation specialists assigned to the clinics coordinate closely with staff employed with the Arizona Department of Economic Security/Rehabilitation Services Administration (DES/RSA). Twenty - eight full – time DES/RSA Vocational Rehabilitation (VR) Counselors are dedicated to persons with SMI, co-located and represented at all the direct care clinic locations. Staff turnover in these positions is a reoccurring challenge. However, as of May 15, 2018, only two VR Counselor positions are

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[69] Each SMI clinical team must include at least one rehabilitation specialist per the MMIC Provider Manual.

[70] The service description for pre-job training and development was revised in August 2017 per telephonic interview with MMIC on May 17, 2018.

reportedly vacant[71]. VR counselors meet regularly with contracted supported employment providers and work in coordination to meet member's supported employment needs.

Most referrals for DES/RSA are initiated by rehabilitation specialists employed by the PNOs/administrative entities and require specified documentation (member diagnosis, face sheet, current assessment, current ISP) to be submitted when referring a candidate for supported employment services. During a telephonic interview with a DES/RSA representative, It was reported that the referral process can proceed in the event that some of the required information is missing or is out of date (e.g., up to two years). In these cases, the VR counselor helps to engage the member with the clinical team to get the documentation updated. The VR counselors facilitate a VR orientation at each clinic each month, which can include from two to 15 members at a time. The orientation provides an overview of VR, a review of program eligibility criteria and presents a "road map" to VR services and supports.

SUPPORTED EMPLOYMENT

DES/RSA data secured from the Maricopa County RBHA included the following:
- RBHA members referred to RSA/VR – 2,844 (January 1, 2017 – November 30, 2017)
- RBHA member served in the VR program – 1,789 (quarter ending September 30, 2017)
- RBHA members open in the VR program – 1,519 (quarter ending September 30, 2017
- RBHA members in service plan status with VR – 938 (quarter ending September 30, 2017)

Additional findings from the service utilization data set are as follows:
- Overall, 26% of the recipients received at least one unit of supported employment during the review period, the same finding identified during CY 2016.
- Access to the service was unevenly split between Title XIX (28%) and non-Title XIX groups (18%).

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[71] Telephonic interview with the Arizona Rehabilitation Services Administration, Statewide Behavioral Health Coordinator, May 15, 2018.

An analysis of the persistence in supported employment services was completed by examining the sustainability of engagement in the service over consecutive monthly intervals.

- Nearly fifty-five percent of the recipients who received at least one unit of supported employment services during the review period accessed the service during a single month;
- 14% of the recipients received supported employment services for three to four consecutive months during the review period; and
- 4% of the recipients received the service for nine consecutive months.

PERSISTENCE IN SUPPORTED EMPLOYMENT SERVICES OCTOBER 2015 — JUNE 2016			
Consecutive months of service	Medicaid recipients	Non-Medicaid recipients	All recipients
1	54.0%	60.3%	54.9%
2	17.8%	17.3%	17.7%
3–4	14.7%	12.1%	14.3%
5–6	6.4%	4.5%	6.2%
7–8	2.6%	2.5%	2.6%
9	4.1%	3.1%	4.0%

SUPPORTED EMPLOYMENT

Key Findings and Recommendations

The most significant findings regarding the need and delivery of supported employment services are presented below. Recommendations are included that should be considered as follow up activities to address select findings.

Findings: Supported Employment

- Service utilization data demonstrates 26% of members received at least one unit of supported employment during CY 2017, the same finding as last year. (CY 2013 – 39%; CY 2014 – 20%; CY 2015 – 17%; CY 2016 – 26%).
- 17% of survey respondents expressed that supported employment services were difficult to access, comparable to last year (21%) and significantly less than CY 2013 and CY 2014 (CY 2013 – 75%; CY 2014 – 33%). 83% of survey respondents indicated that supported employment services were easy to access or having "fair" access, an increase from CY 2016 (79%) and substantially higher than CY 2014 (66%).
- Focus group participants reported an increase in the number of VR specialists co-located at the clinics. While there is noted variation in the timely access to VR services, participants expressed that the increased availability of VR specialists is a positive development.
- Participants in the provider and case manager focus groups stated that members are encouraged to pursue a wider variety of employment opportunities outside of peer support specialist training and employment. Provider organizations are now co-located at

the clinics leading to more diverse opportunities for members. Case manager participants also reported that they continue to observe an increase in the number of employers willing to hire individuals with SMI diagnoses.

- Nearly fifty-five percent of the members who received at least one unit of supported employment services during the review period accessed the service during a single month. Mercer was unable to discern if this finding is predominantly the result of rapid job placement or if a majority of members are unable to sustain ongoing involvement in supported employment services.
- In 77 cases, reviewers were able to review progress notes and record the reasons why the member did not access supported employment services after a supported employment need was identified by the clinical team. A lack of evidence that the clinical team followed up with initiating a referral for the service was noted in 40% of those cases in which the member did not access the service despite an identified need – the same result identified during CY 2016.
- Based on the review of medical records, Mercer identified the following issues:
  - Assessed needs and corresponding individual service plan interventions are commonly misaligned and suggest that some clinical teams responsible for developing the service plan in coordination with the member do not fully understand the appropriate application of the priority mental health services, including supported employment.
  - Individual service plans are not always based on the member's assessed needs and can include generic language that does not differentiate each member's unique circumstances and needs.
  - The most prevalent reason noted by Mercer's review team for why members don't access services identified on the individual service plan is that there is a lack of documentation that the clinical team follow up with referring and coordinating access to the service(s). However, if the services identified on the individual service plan are not based on the member's assessed needs as illustrated by a subset of the sample of medical records; the member may have never required the service in the first place.

SUPPORTED EMPLOYMENT

- Consistent with patterns noted over the past four years, the service utilization data set demonstrates proportional variation in the volume of encountered service codes for supported employment. For the time period October 1, 2016 through June 30, 2017, H2027 (pre-job training and development) accounts for 94% of the total supported employment services (increase from CY 2016 – 87%).
- Per the RBHA, the primary role of the rehabilitation specialists are to assess members' needs to get involved in vocational rehabilitation or employment services, but should not be providing direct pre-job training and development services (i.e., H2027).[72] Mercer confirmed that rehabilitation specialists are documenting progress notes with supported employment bill codes (i.e., H2027) through the medical record reviews of a sample of SMI members, but also noted that rehabilitation specialists were regularly billing case management activities as well.
- The RBHA acknowledged that "identified areas of concern" have been noted with rehabilitation specialist staffing vacancies and are currently following up with the PNOs and administrative entities to gather additional information and may consider initiating contract enforcement actions with select PNOs and/or administrative entities.
- DES/RSA data secured from the Maricopa County RBHA includes the following:

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[72] The service description for pre-job training and development was revised in August 2017 per a telephonic interview with MMIC on May 17, 2018.

- RBHA members referred to RSA/VR – 2,844 (January 2017 – November 30, 2017)
  - RBHA members served in the VR program – 1,789 (quarter ending September 30, 2017)
  - RBHA members open in the VR program – 1,519 (quarter ending September 30, 2017)
  - RBHA members in service plan status with VR – 938 (quarter ending September 30, 2017).
- As reported by the Maricopa County RBHA, supported employment contracted capacity is capable of serving at least 770 members.

Recommendations: Supported Employment

- Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and/or maintaining employment.
- Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services.
- Monitor (and take actions as appropriate) the observed practice of indiscriminately documenting supported employment services on members' individual service plans without evidence of an assessed need for the service.
- Create educational materials, available in the lobbies of the clinics, which describe basic information about employment and its impact on member health and welfare benefits.
- Use peer support specialists to engender interest in working by hosting groups and other forums in which peer support specialists "tell their story" about the benefits of finding and maintaining employment.
- Incentivize and reward supported employment providers that successfully transition members from pre-job training and development services to job search and job maintenance services.

SUPPORTED EMPLOYMENT

- Review the effectiveness of current provider monitoring activities to ensure that individual service plans are based on the member's assessed needs and are specific to the member's individual circumstances. When performance deficiencies are identified, initiate remedial actions with providers including technical assistance, performance improvement initiatives and/or corrective action plans.
- Standardize job responsibilities and functions for required rehabilitation specialist staffing positions, including clarification regarding the direct provision of supported employment services.
- Ensure contractual requirements for assigning rehabilitation specialists to each clinical team are met and take appropriate actions if staffing vacancies persist or reoccur with contracted providers.

SUPPORTED HOUSING

Service Description

Supported housing is permanent housing with tenancy rights and support services that enable recipients to attain and maintain integrated affordable housing. It enables recipients to have the choice to live in their own homes and with whom they wish to live. Support services are flexible and available as needed but not mandated as a condition of maintaining tenancy. Supported housing also includes rental subsidies or vouchers and bridge funding to cover deposits and other household necessities, although these items alone do not constitute supported housing.

Focus Groups

Key themes related to supported housing services included:

- Participants in the case manager focus group reported satisfaction with the services provided by agencies that provide supported housing services and that there has been in an increase in the number of supported housing vendors. These vendors assist members to find and maintain housing and are also able to mediate issues that may preempt an eviction. In turn, supported housing providers reported they are experiencing success with the members they serve and are graduating members out of their programs.
- Case managers also report that the increase in supported housing providers has resulted in improved member choice and the provision of more individually-tailored services. Case managers understand which agencies will work best with their members and make referrals accordingly.
- Case managers shared that supported housing referrals and communication and coordination with the vendors is conducted timely and efficiently via staffings and electronic mail.
- Case manager focus group participants shared that the expanded recruitment of housing navigators has been a positive change since last year. Housing navigators are peers who help members to access housing start-up kits, research housing options, help members navigate through the leasing process and apply for move-in and moving assistance if needed.
- Case manager and family member participants stated that the clinics also employ housing specialists. These individuals coordinate with the housing navigators and assist case managers with discharge planning from hospital settings and address housing needs. The housing specialists also coordinate with landlords to address issues that could lead to a loss of housing.
- Similar to the last two years, the insufficient capacity of available, affordable and safe housing units, including transitional housing, remains a primary concern of focus group participants. It remains a particular challenge to locate housing for members with records of multiple evictions or felonies.
- Focus group participants expressed concerns about increasing prices in market rent which contributes to the lack of capacity. Many apartment complexes are being revamped, also resulting in an increase in rent and a reduction in lease renewals.
- Case manager participants reported that the housing voucher wait list through the RBHA is approximately one-year. Similar to previous years, case managers expressed difficulty obtaining information about a member's status on the list.
- Provider focus group participants reported that while the housing voucher wait list through the RBHA remains long, the wait list for scattered-based vouchers has reduced to 60 days from 9 months.
  Case manager and provider focus group participants expressed concerns about some of the housing voucher vendors. Case managers felt that these vendors are taking too long to complete the required inspections (sometimes in excess of a month). Case

SUPPORTED HOUSING

managers must find other resources to prevent members from becoming homeless while they wait for the housing inspection to be completed. Provider focus group participants reported that these vendors can also get behind in paying rent. This places members' housing at risk.

- Some family members report that they do not know who to speak to about housing options for their family members while others shared that there has been an improvement in the training provided to case managers regarding housing options. One family member stated, "My son receives a voucher and pays 30% of the rent. My clinical team offered this as a resource after I stated that he could no longer live with me. My son is doing fantastic and is very happy."
- Similar to last year, participants expressed a need for additional assisted living housing that will support the needs of aging and elderly members.

Key Informant Survey Data

As part of an effort to obtain comprehensive input from key system stakeholders regarding the availability, quality and accessibility of supported housing services, a key informant survey was administered. The survey tool included questions and rating assignments related to the priority mental health services. The survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

42% of the survey respondents felt that supported housing services were difficult to access, down from 46% a year ago. One (4%) of the respondents indicated that supported housing services were inaccessible, a significant improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.

54% of respondents indicated that supported housing services had "fair access" or were easy to access. When asked about the factors that negatively impact accessing supported housing services, the responses are as follows:

28% of the responses indicated that a wait list exists for the service; (25% during CY 2013; 63% during CY 2014; 59% during CY 2015; 45% during CY 2016);

- 22% of the responses were directed to a lack of capacity/no service provider available (31% during CY 2013; 50% during CY 2014; 38% during CY 2015; 37% during CY 2016); and
- 15% percent selected admission criteria for services too restrictive (25% during CY 2013; 31% during CY 2014; 26% during CY 2015; 20% during CY 2016).

Ability to access services
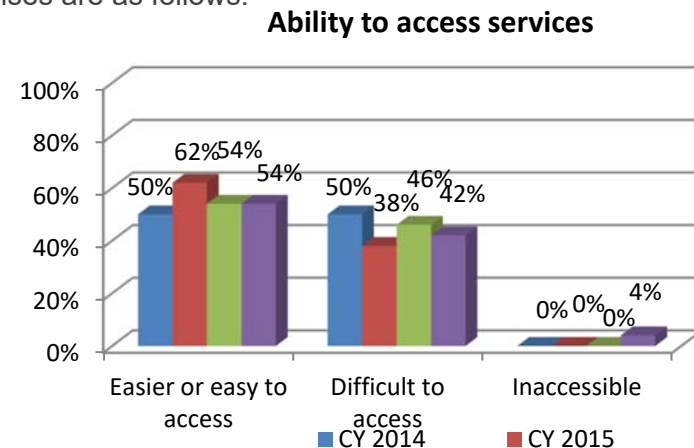
SUPPORTED HOUSING

In terms of service utilization:
- 26% of the responses indicated that the services were being utilized efficiently (10% during CY 2013; 25% during CY 2014; 31% during CY 2015; 33% during CY 2016);
- 52% responded that the services were utilized efficiently most of the time (30% during CY 2013; 50% during CY 2014; 38% during CY 2015; 42% during CY 2016); and
- 22% of the respondents indicated that supported housing services were not utilized efficiently (60% during CY 2013; 25% during CY 2014; 26% during CY 2015; 24% during CY 2016).

20% of the survey respondents reported that supported housing services could be **accessed within 30 days** of the identification of the service need (11% during CY 2013; 0% during CY 2014; 17% during CY 2015; 21% during CY 2016).

30% of the respondents indicated that the service could be **accessed on average within four to six weeks** (22% during CY 2013; 0% during CY 2014; 4% during CY 2015; 11% during CY 2016).

50% of the survey respondents reported that it would take an **average of six weeks or longer to access** supported housing services (67% during CY 2013; 92% during CY 2014; 78% during CY 2015; 68% during CY 2016).

Medical Record Reviews: Group 1
The Group 1 medical record review sought to answer the following questions regarding the assessment and provision of supported housing services:
- Is there evidence that supported housing services were assessed by the clinical team?
- When assessed as a need, are supported housing services identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for supported housing services?

Findings specific to supported housing services are presented below.
- The Group 1 medical record review looked for evidence that the recipients were in need of supported housing services. 23 cases or 19% of the sample demonstrated an assessed need for supported housing.
- When assessed as a need, supported housing related services were identified on the recipient's ISP in 43% of the records (20% during CY 2013; 19% during CY 2014; 50% during CY 2015; 35% during CY 2016).

9% of the Group 1 recipients received at least one unit of supported housing services during CY 2017 based on a review of service utilization data.

SUPPORTED HOUSING

Interviews

All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview revealed the following:

- 47% of the recipients interviewed reported that the clinical team did discuss housing related supports and services.
- Disagreement between the clinical team's assessment and the recipient's perception of need was found in 39% of the cases reviewed (44% during CY 2014 and 41% during CY 2015; 36% during CY 2016).

Medical Record Reviews: Group 2

Consistent with prior year evaluations, the recipient's living situation was assessed and documented in almost all the cases reviewed.

- Supported housing services were identified as a need on either the recipient's assessment and/or recipient's ISP in 31% of the cases reviewed.
- Supported housing was identified as a service on the recipient's ISP in 74% of the cases when identified as a need. (up from last year when 53% of the ISPs included supported housing)

9% of the recipients included in the Group 2 sample received a unit of supported housing during CY 2017.

In twenty-eight cases, reviewers were able to review progress notes and record the reasons that the person was unable to access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.

In some cases, Mercer's review team noted that the clinical Team assessed a need for supported housing, but the corresponding individual service plan did not include a supported housing service or intervention.

Supported housing

	CY 2014	CY 2015	CY 2016	CY 2017
Were supported housing services identified as an explicit need on the recipient's assessment?	36%	21%	17%	27%
Were supported housing services identified as an explicit need on the recipient's ISP?	31%	24%	13%	22%
Were supported housing services identified as a service on the recipient's ISP?	27%	48%	53%	74%
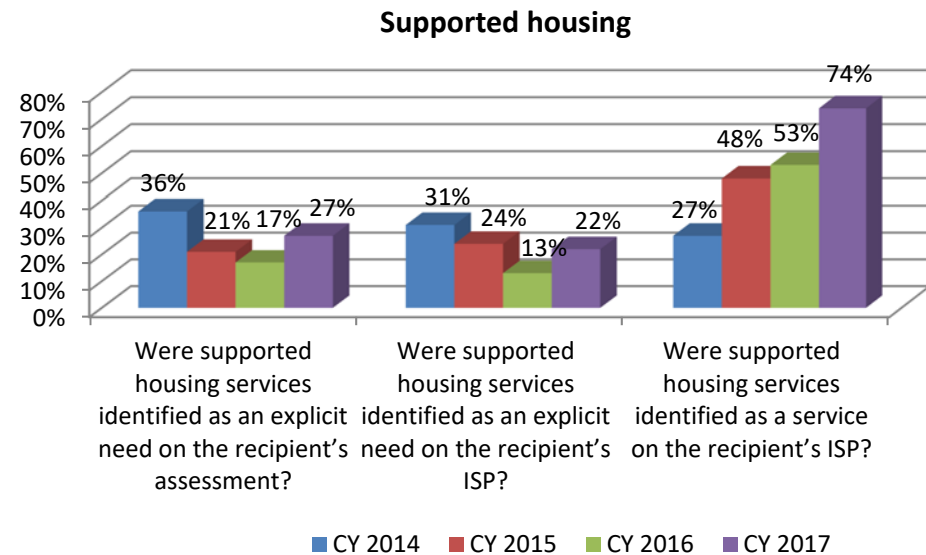
SUPPORTED HOUSING

To illustrate this finding, one case reviewed included an assessment with the following statement: "Member needs housing ASAP". However, the corresponding individual service plan, dated the same date as the member's assessment and signed off by the clinic's clinical leadership (i.e., a medical doctor), did not include any goals, objectives are services to meet the member's urgent housing needs as conveyed through the assessment.

Service Utilization Data
Permanent supported housing utilization includes skills training and development and personal care services to help members obtain and maintain community-based independent living arrangements. In addition to these services, targeted services for contracted permanent supported housing providers can include behavioral health prevention and education, peer support, case management, behavioral health screening and assessment, non-emergency transportation, medication training and support, counseling, personal care and psychoeducational services.

As indicated within the service utilization data file, 1,974 Title XIX eligible (Medicaid) recipients were affiliated with the service during the time period of October 1, 2016 – December 31, 2017 and 124 non-Title XIX recipients received the service from a total population of 31,712 (7%).

Key Findings and Recommendations
The following information summarizes key findings identified as part of the service capacity assessment of supported housing.

Findings: Supported Housing
- Service utilization data reveals that 7% of members received at least one unit of supported housing during the review period.
- Focus group participants expressed concerns about increasing prices in local market rent which can contribute to a lack of housing capacity. Participants also noted that many apartment complexes are being renovated, also resulting in increases in rent and a reduction in lease renewals for members.
- Case manager focus group participants shared that the expanded recruitment of housing navigators has been a positive development since last year. Housing navigators are peers who help members to access housing start-up kits, research housing options, help members navigate through the leasing process, and for move-in and moving assistance if needed.
- In twenty-eight cases, reviewers were able to review progress notes and record the reasons that the person did not access supported housing services after housing-related assistance was identified as a need by the clinical team. The most common reason was that there was a lack of evidence that the clinical team followed up with initiating a referral for the service.
- 42% of the survey respondents indicated that supported housing services were difficult to access, down from 46% a year ago. One (4%) respondent indicated that supported housing services were inaccessible, a significant improvement from CY 2013 when 17% of the key informants felt that the services were inaccessible.
- 50% of the survey respondents reported that it would take an average of six weeks or longer to access supported housing services (67% during CY 2013; 92% during CY 2014; 78% during CY 2015; 68% during CY 2016).

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- Supported housing was identified as a service on the member's individual service plan in 74% of the cases when identified as a need by the clinical team (up from last year when 53% of the ISPs included supported housing).
- As reported by the Maricopa County RBHA, permanent supported housing contracted capacity is capable of serving at least 1,265 members.

Recommendations: Supported Housing

- Promote more robust clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing supported housing needs of members.
- Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and maintaining independent living arrangements.
- Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported housing services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services.

ASSERTIVE COMMUNITY TREATMENT TEAMS

Service Description:

An ACT team is a multi-disciplinary group of professionals including a psychiatrist, a nurse, a social worker, a substance abuse specialist, a vocational rehabilitation specialist, and a peer specialist. Services are customized to a recipient's needs and vary over time as needs change.

Focus Groups

Key findings derived from focus group meetings regarding ACT team services are presented below:

- Case manager focus group attendees reported that new members are unable to be assigned directly to an ACT team regardless of acuity. Rather, the member must be assigned to a supportive team before being considered for an ACT team.
- Similar to last year, participants in the case manager focus group reported that criteria for ACT admissions remain unclear and that reasons for non-acceptance of ACT team services are rarely provided. Provider focus group participants added that admission to ACT teams appears to be subjectively-based and is dependent on the individual conducting the assessment.
- Provider focus group participants shared that case managers do not seem to understand which members are appropriate for ACT and recommend training to support appropriate identification and referral.
- Similar to the last two years, participants reported that not all clinics have an ACT team or an ACT team in close proximity to the clinic. Some members who would benefit from ACT team services decline enrollment with an ACT team because they do not want to be served by another clinic or have to move to be closer to an ACT team.
- Participants in the case manager and provider focus groups stated that ACT teams are frequently at capacity and there is a need for more specialty ACT teams such as medical and forensic ACT teams.

- Provider and case manager focus groups participants reported that the forensic teams may only consider referrals from criminal justice entities such as probation and parole. Participants recommended allowing the clinics and mental health courts to make referrals as well, which would allow other members to gain access to this specialized service.
- Similar to last year, it was reported that members assigned to medical ACT teams are required to change primary care providers (PCPs) if they are not currently assigned to the PCP on the ACT team. For some members the reassignment of PCPs was reported to disrupt continuity of care.
- Last year, provider agency and family member participants expressed concerns that individuals on ACT teams are excluded from participating in non-ACT-delivered services such as individual and group peer support and family support services due to ACT fidelity requirements. Family mentors and peer support specialists reported that other members lose connections to long-standing group activities and relationships once they are assigned to an ACT team. This year, provider agency participants stated that they do allow ACT members to access clinic-based peer services even if they are admitted to the ACT program because they believe this is in the best interest of the members.
- Similar to last year, some ACT teams are fully staffed while others experience higher attrition rates and frequent staff vacancies (particularly for peer support specialist positions).

ASSERTIVE COMMUNITY TREATMENT TEAMS

- Family member focus group participants reported that their family members who currently utilize or have utilized ACT team services in the past said their ACT team was beneficial to them. One family member stated, "I think ACT teams are amazing. They work so hard and are top of everything." Other family members reported that they had never heard of ACT and did not know who to speak to about accessing this service for a family member.

Key Informant Survey Data

As part of an effort to obtain input from key system stakeholders regarding the availability, quality and access to ACT team services, a key informant survey was administered. The survey tool included questions and rating assignments related to ACT team services. As noted previously, the survey distribution process targeted a defined list of key system stakeholders and responses to the survey do not represent a statistically significant sample of all potential informants. As such, survey results should be reviewed in the context of qualitative and supplemental data and should be not be construed to be representative of the total population of system stakeholders.

14% of survey respondents reported that ACT team services were difficult to access (46% during CY 2013; 33% during CY 2014; 23% during CY 2015; 24% during CY 2016) and none of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013). 86% of respondents indicated that ACT team services had "fair access" or were easy to access (36% during CY 2013; 50% during CY 2014; 77% during CY 2015; 73% during CY 2016).

When asked about the factors that negatively impact accessing ACT team services, the responses are as follows:
- 32% indicated that the member declines service (20% – CY 2013; 50% – CY 2014; 41% – CY 2015; 43% – CY 2016).

- 27% of the responses identified clinical team unable to engage/contact member (27% during CY 2013; 32% during CY 2014; 45% – CY 2015; 41% – CY 2016);
- 18% selected staffing turnover (CY 2014 – 32%; CY 2015 – 41%; CY 2016 – 35%).

In terms of the efficiency of service utilization:
- 42% of the responses indicated that the services were being utilized efficiently (CY 2013 – 27%; 19% – CY 2014; 29% – CY 2015; 30% – CY 2016);
- 47% responded that the services were utilized efficiently most of the time (CY 2013 – 18%; CY 2014 – 56%; CY 2015 – 63%; CY 2016 – 58%); and
- 11% of the respondents indicated that ACT team services were not utilized efficiently (55% during CY 2013; 6% during CY 2014; 8% during CY 2015; 13% during CY 2016).

94% of the survey respondents reported that ACT team services could **be accessed within 30 days** of the identification of the service need (CY 2013 – 60%; CY 2014 – 58%; CY 2015 – 77%; CY 2016 – 75%). 0% indicated that the service could be **accessed on average, within four to six weeks** (20% – CY 2013; 6% – CY 2014; 5% – CY 2015; 8% – CY 2016). The remaining 5% of the survey

<div style="background:#1cb5c9;color:white;text-align:center;font-weight:bold">ASSERTIVE COMMUNITY TREATMENT TEAMS</div>

respondents reported that it would take an **average of six weeks or longer to access** ACT team services (20% – CY 2013; 33% – CY 2014; 18% – CY 2015; 17% – CY 2016).

Medical Record Reviews: Group 1
The Group 1 medical record review sought to answer the following questions regarding the assessment and provision of the priority mental health services:
- Is there evidence that ACT team services were assessed by the clinical team?
- When assessed as a need, are ACT team services identified on the recipient's ISP?
- Is the clinical team's assessment consistent with the recipient's perception regarding the need for ACT team services?

3% of the Group 1 records included evidence that the clinical team assessed and/or documented a need for ACT team services.

When assessed as a need, 50% of the records identified ACT team services on the recipient's ISP.

3% of the Group 1 sample included members assigned to an ACT team.

Interviews
All Group 1 recipients participated in an interview regarding the prioritized mental health services.

The interview disclosed the following:

- 28% of members recalled the clinical team discussing ACT team services during the annual assessment and service planning process. The review team observed that an assessment regarding the appropriateness of the member's assigned level of case management is typically not documented as part of the annual assessment and treatment planning process.
- 84% of the members agreed with the clinical team's assessment regarding the need for ACT team services.

Medical Record Reviews: Group 2

Consistent with the past three years, in most cases reviewed, there was little to no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management.

In thirty-four cases, ACT team services were identified as a need on recipients' assessments and/or ISPs. Only three of these cases identified "ACT team services" on the ISP.

In most of the remaining cases, ISPs would identify case management services as the intervention to meet an assessed need for ACT.

ASSERTIVE COMMUNITY TREATMENT TEAMS

18% of the recipients included in the sample were assigned to an ACT team.

Assessment of need for ACT

	Were ACT team services identified as an explicit need on the recipient's assessment?	Were ACT team services identified as an explicit need on the recipient's ISP?	Were ACT team services identified as a service on the recipient's ISP?
CY 2014	6%	3%	8%
CY 2015	5%	5%	9%
CY 2016	11%	10%	9%
CY 2017	16%	16%	9%
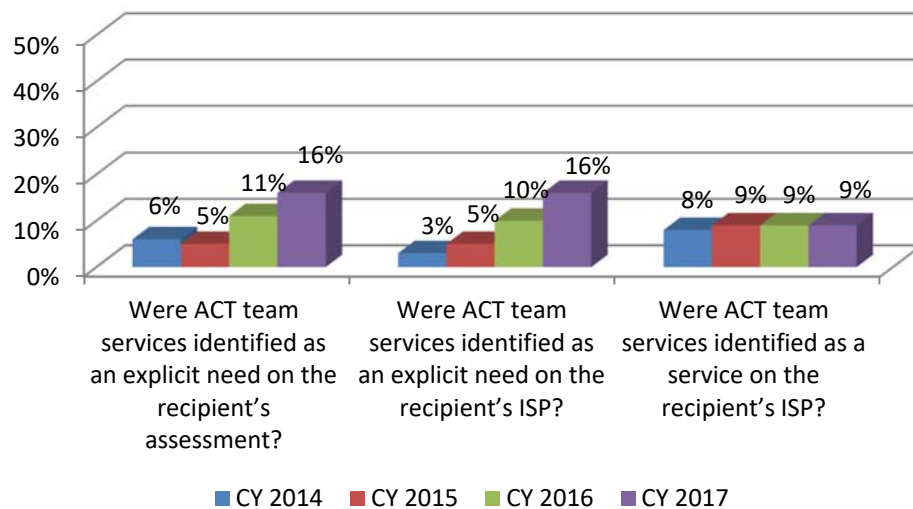
Service Utilization Data

ACT team services are not assigned a specific billing code. Therefore, ACT team services are not uniquely reflected in the service utilization data file.

Mercer did complete an analysis of service utilization for recipients that were assigned to an ACT team. CY 2017 service utilization profiles for 2,056 ACT team members who received a behavioral health service were analyzed.

The analysis sought to identify the utilization of one or more of the priority services (supported employment, supported housing, peer support services, family support services).

ASSERTIVE COMMUNITY TREATMENT TEAMS

The analysis found that 72% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 44%. Utilization of supported housing services was found to be 18% across the identified ACT team members.

ACT recipients receiving priority mental health services

Bar chart legend: ■ CY 2015 ■ CY 2016 ■ CY 2017

Category	CY 2015	CY 2016	CY 2017
Peer support	57%	79%	72%
Family support	5%	8%	5%
Supported employment	29%	49%	44%
Supported housing	6%	37%	18%
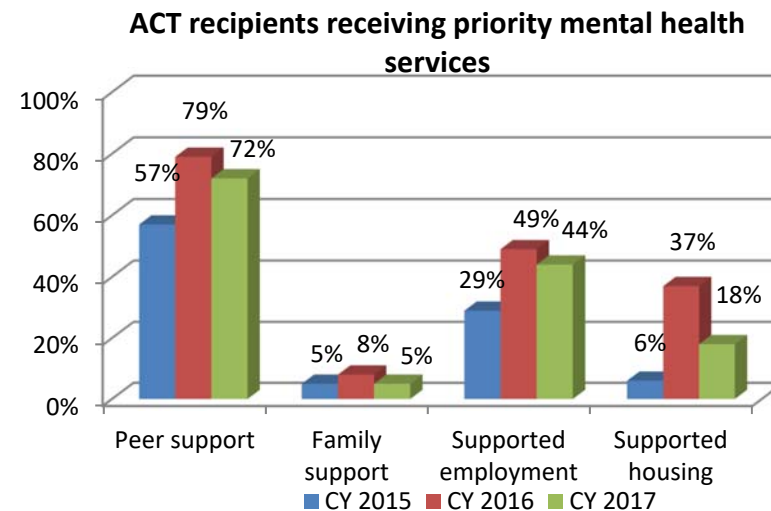
Key Findings and Recommendations

Findings: ACT Team Services

- As a percentage of the total SMI population, 7% of all members are assigned to an ACT team. This is the same finding observed during CY 2015 and CY 2016, and slightly higher than the finding derived during CY 2013 and CY 2014 (6%).
- Mercer completed an analysis of service utilization data for recipients that were assigned to an ACT team. CY 2017 service utilization profiles for 2,056 ACT team members who received a behavioral health service were analyzed. The analysis found that 72% of the ACT team members received peer support services during the review period. ACT recipients who received supported employment services was determined to be 44%. Utilization of supported housing services was found to be 18% across the identified ACT team members.

- Similar to last year, participants in the case manager focus group reported that criteria for ACT admissions remain unclear and that reasons for non-acceptance of ACT team services are rarely provided. Provider focus group participants added that admission to ACT teams appears to be subjectively-based and is dependent on the individual conducting the assessment.
- Provider and case manager focus groups participants reported that the forensic teams may only consider referrals from criminal justice entities such as probation and parole. Participants recommended allowing the clinics and mental health courts to make referrals as well, which would allow other members to gain access to this specialized service.

ASSERTIVE COMMUNITY TREATMENT TEAMS

- 14% of survey respondents reported that ACT team services were difficult to access (46% during CY 2013; 33% during CY 2014; 23% during CY 2015; 24% during CY 2016) and none of the respondents indicated that the service was inaccessible (18% perceived the services inaccessible during CY 2013). 86% of respondents indicated that ACT team services had "fair access" or were easy to access (36% during CY 2013; 50% during CY 2014; 77% during CY 2015; 73% during CY 2016).
- 3% of the Group 1 records included evidence that the clinical team assessed and/or documented a need for ACT team services. Consistent with the past three years, in most cases reviewed, there was little to no documented evidence that the clinical team was considering or recommending a change in the level of case management, including referring a person to an ACT team or stepping down a recipient assigned to an ACT team to a less intensive level of case management.
- A review of 100 SMI members that represent the highest aggregate behavioral health service costs during CY 2017 was conducted. It was determined that 26% of the members were assigned to an ACT team. This compares to 20% when the same analysis was completed during CY 2013, 18% during CY 2014, 23% during CY 2015 and 25% during CY 2016. Of the 26 members assigned to ACT and included on the list of the top 100 members with the highest behavioral health service costs; 9 (36%) also resided in supervised behavioral health residential settings. During times of transition (admission or discharge from ACT team services), it may be appropriate to temporarily have a member assigned to ACT and placed in a supervised setting, but this should be time-limited due to the duplicative nature of the services. Overall, 41 of the 100 (41%) members resided in a supervised behavioral health residential setting, which may contribute to higher service costs for those members and may discourage clinical teams from considering or referring a member to an ACT team. If members placed in a supervised behavioral health residential setting (and not currently assigned to an ACT team) are excluded from the analysis, then 33% of the highest cost utilizers are assigned to an ACT team.
- An analysis of jail booking data was completed to identify members that have had multiple jail bookings over a defined period (i.e., eleven months—January 2017 through November 2017) and determine if the member was subsequently referred and assigned to an ACT team, including one of the three forensic specialty ACT teams. The analysis found:
  – 391 members experienced at least two jail bookings during the period under review (467 for same time period in CY 2016; 408 for same time period in CY 2015).
  – Of these 391 members, 63 (16%) were assigned to an ACT team (CY 2016 – 25%; CY 2015 – 23%) during the review period.
  – Of the 63 members assigned to an ACT team, 18 (29%) are assigned to a forensic specialty ACT team (CY 2016 – 22%; CY 2015 – 20%).
  – 22 members receiving ACT team services have 3 or more incarcerations over the review period, but are not assigned to one of the three available forensic specialty ACT teams.

- 2,233 members were assigned to 24 ACT teams as of December 1, 2017. The same number of teams as CY 2016, but an increase of 141 members.

ASSERTIVE COMMUNITY TREATMENT TEAMS

Recommendations: ACT Team Services

- Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients.
- Consider expanding referral sources that can identify and recommend members to forensic ACT teams and utilize available data to inform decision making. For example, utilize cost and criminal justice recidivism data to identify potential candidates for these specialty ACT teams.
- As part of the annual assessment update, intentionally review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management. As part of the annual assessment update, document that this review occurred.
- Clinical teams should regularly evaluate opportunities for current ACT team members to step down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record.

Outcomes Data Analysis

The service capacity assessment utilized an analysis of recipient outcome data in an attempt to link receipt of one or more of the priority mental health services with improved functional outcomes. The relationships between outcomes and service utilization trends may be identified, but those relationships do not necessarily reflect causal effects. As such, observed outcomes may be contingent on a number of variables that are unrelated to receipt of one or more of the priority mental health services. Consistent with prior year's analyses, the review team selected the following outcome indicators:

- Criminal justice records (i.e., number of arrests);
- Homeless prevalence (i.e., primary residence); and
- Employment status.

During CY 2017, an analysis was completed that compared recipients' persistence with receiving supported employment services and peer support services for each of the outcome indicators selected. Overall, there are strong relationships between receipt of the priority

services and improved outcomes related to incarcerations, living situation and employment status. The relationship is further strengthened when the recipient sustains consistent participation in the priority service over an extended period of time.

ASSERTIVE COMMUNITY TREATMENT TEAMS

The following results were noted when reviewing select outcomes for recipients who had received supported employment services:

- Similar to CY 2016 results, the percentage of recipients identified as unemployed decreases as the duration with supported employment services increases. 74% of recipients identified as unemployed are associated with two or less consecutive months of supported employment services. Alternatively, recipients who experienced five or more consecutive months of supported employment services constituted only 7% of the total unemployed group.

The following outcomes were noted when reviewing recipients who had received peer support services during the review period:

- Of the group of recipients who were incarcerated during the review period, only 3% received seven to eight consecutive months of peer support services. 74% of recipients who had experienced an incarceration received peer support services during a single month or during two consecutive months during the review period.
- Less than one third (29%) of members noted to be homeless or residing in a boarding home, crisis shelter, hotel, or behavioral health treatment setting received peer support services during the review period.
- Longer periods of consecutive peer support services are also associated with lower unemployment rates. 65% of the recipients identified as unemployed received one or two months of peer support services; the percentage of unemployed recipients who received peer support services for seven or eight consecutive months was determined to be 6%.

Unemployed recipients receiving consecutive months of supported employment
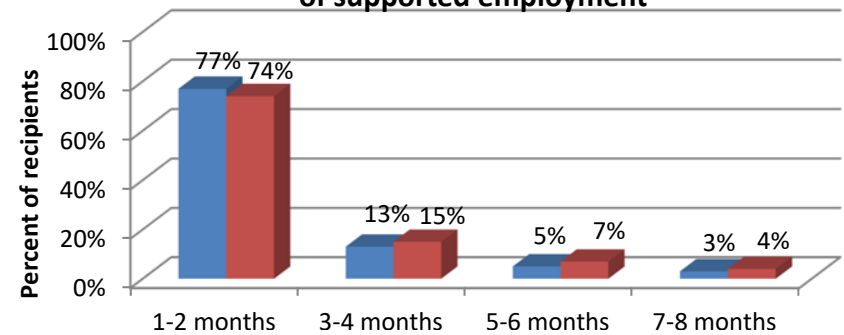
Incarcerated recipients receiving consecutive months of peer support
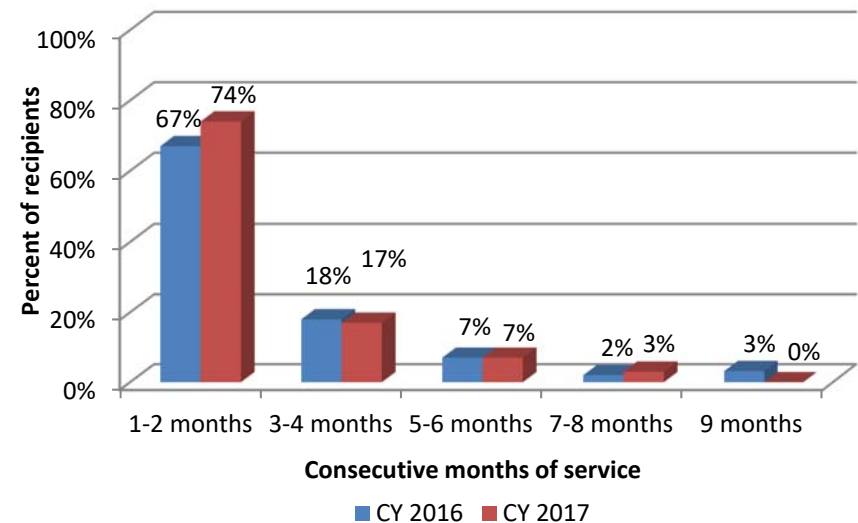
ASSERTIVE COMMUNITY TREATMENT TEAMS

The Maricopa County RBHA has also implemented a value-based purchasing initiative and is monitoring designated performance measures that tie to improved member outcomes. The purpose of the initiative is to encourage continuous quality improvement and learning, particularly initiatives that target improved health outcomes and cost savings. Performance measure results reported by the RBHA that are directly relevant to the Maricopa County SMI population and the priority mental health services are summarized below[73].

For ACT team providers, findings include:
- Psychiatric hospitalizations per 1000 members have decreased 21% (compared to 8% during CY 2016);
- Medical hospitalizations per 1000 members have decreased 12%;
- Emergency department visits per 1000 members have decreased by 11% (compared to 6% during CY 2016);
- Members competitively employed per 1000 members have increased 100%; and
- Homelessness per 1000 members have decreased by 19%.

For Forensic ACT team providers, findings included:
- A forensic ACT team achieved a 57% reduction in the number of jail bookings;
- A 54% (compared to 31% during CY 2016) reduction in psychiatric hospital admissions;
- A 27% (compared to 18% during CY 2016) reduction in emergency department visits; and
- A 45% reduction in medical hospital admissions.

For permanent supporting housing providers, findings include:
- A 52% (compared to 60% during CY 2016) reduction in psychiatric hospital admissions was observed for members affiliated with a participating supported housing service provider;
- A 40% (compared to 49% during CY 2016) reduction in the number of members who utilized a mobile crisis service; and
- 99.6% of members maintained stable housing once secured.

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[73] As reported by the Maricopa County RBHA, correspondence dated May 11, 2018.

APPENDIX A
FOCUS GROUP INVITATION

MERCER
MAKE TOMORROW, TODAY

On behalf of the Arizona Health Care Cost Containment System (AHCCCS), Mercer Government Human Services Consulting (Mercer) is conducting four focus groups in Maricopa County.

This is the fifth year of Mercer's evaluation of adults with serious mental illness (SMI) access to Priority Mental Health Services (PMHS): Assertive Community Treatment (ACT), Supported Housing (SH), Supported Employment (SE) and Peer and Family Support Services. The evaluation includes a review of system strengths, challenges, barriers and concerns related to priority behavioral health services. This information will be used to inform strategies to help the adult system of care in Maricopa County continue to grow and support recovery-oriented services.

Focus groups will be held at the following location:
The Refuge
4727 N. 7th Ave., Phoenix, AZ 85013

Focus Group One	Focus Group Two
Adults receiving SMI Priority Mental Health Services	*Direct Care Clinic Case Managers* providing SMI Priority Mental Health Services to Adults
Wednesday, February 21, 2018 10:00 am–12:00 pm	Wednesday, February 21, 2018 2:00 pm–4:00 pm

Focus Group Three	Focus Group Four
Family Members of Adults Receiving SMI Priority Mental Health Services	*Providers of ACT, SH, SE, Peer and Family Support Services* to adults receiving SMI Priority Mental Health Services
Thursday, February 22, 2018 11:00 am–1:00 pm	Thursday, February 22, 2018 2:00 pm–4:00 pm

Space is available for 15 participants per focus group and all RSVPs will be confirmed by email.
Once capacity is reached, interested participants will be placed on a waiting list.
RSVP by Wednesday, February 16, 2018 to Laura Henry at laura.henry@mercer.com
Refreshments will be provided.

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MARSH & McLENNAN COMPANIES

APPENDIX B
KEY INFORMANT SURVEY

Mercer AHCCCS Priority Mental Health Services: Key Informant Survey 2018

* 1. Please indicate if you provide the following behavioral health services to adults with a SMI.

	Yes	No
Assertive Community Treatment (ACT)	○	○
Family Support Services	○	○
Peer Support Services	○	○
Supported Employment	○	○
Supported Housing	○	○

* 2. Based on your experience as a provider, rate the level of accessibility to each of the priority services. 1=No Access/Service Not Available, 2=Difficult Access, 3=Fair Access, 4=Easy Access, NA=I do not have experience with this service

	1	2	3	4	N/A
ACT	○	○	○	○	○
Family Support Services	○	○	○	○	○
Peer Support Services	○	○	○	○	○
Supported Employment	○	○	○	○	○
Supported Housing	○	○	○	○	○

ˈ 3. Please identify the factors that hinder access to each of the priority services (select all that apply).

	Member Declines Service	Wait List Exists for Service	Language or Cultural Barrier	Transportation Barrier	Clinical Team Unable to Engage/Contact Member	Lack of Capacity/No Service Provider Available	Admission Criteria for Services too Restrictive	Staffing Turnover	Other
ACT	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family Support Services	☐	☐	☐	☐	☐	☐	☐	☐	☐
Peer Support Services	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supported Employment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Supported Housing	☐	☐	☐	☐	☐	☐	☐	☐	☐

If you checked other above (please specify)

ˈ 4. Are the priority services below being utilized efficiently?

	Yes	Most of the Time	No	N/A
ACT	○	○	○	○
Family Support Services	○	○	○	○
Peer Support Services	○	○	○	○
Supported Employment	○	○	○	○
Supported Housing	○	○	○	○

* 5. After a priority service need is identified by the clinical team, member, and family (as applicable), how much time elapses before the member accesses the service? Please respond for each priority service. NA = I do not have experience with this service.

	1-2 Weeks	3-4 Weeks	4-6 Weeks	Longer than 6 weeks	NA
ACT	○	○	○	○	○
Family Support Services	○	○	○	○	○
Peer Support Services	○	○	○	○	○
Supported Employment	○	○	○	○	○
Supported Housing	○	○	○	○	○

* 6. Over the past 12 months, to what degree has access to each of the priority services changed? 1=easier to access, 2=more difficult to access 3=no change

	1	2	3
ACT	○	○	○
Family Support Services	○	○	○
Peer Support Services	○	○	○
Supported Employment	○	○	○
Supported Housing	○	○	○

* 7. Describe the most significant service delivery issue(s) for the persons with a SMI accessing behavioral health services in Maricopa County.

* 8. What is your job role/title?

○ CEO

○ Executive Management

○ Clinical Leadership (behavioral health)

○ Clinical Leadership (medical)

○ Specialty Case Manager

○ Direct Services Staff (BHP/BHT)

○ Other (please specify)

[   ]

* 9. From the list below, please select which best describes your organization.

○ ACT Team Provider

○ Behavioral Health Provider for Adults with a Serious Mental Illness (SMI) Only

○ Behavioral Health Provider for Adults with a SMI, Children, General Mental Health/Substance Abuse

○ Consumer Operated Agency (peer support services/family support services for adults)

○ Crisis Provider

○ Hospital

○ Provider Network Organization or other Administrative Entity within the Maricopa County Regional Behavioral Health Authority System

○ Supported Employment Provider

○ Supported Housing Provider

○ Other (please specify)

[   ]

APPENDIX C
ASSESSMENT VERIFICATION INTERVIEW TOOL

MERCER

ASSESSMENT VERIFICATION INTERVIEW

Recipient Name: _____

Provider Network Organization: _____

Clinic: _____

Date: _____

Interviewer: _____

1. When you met with your clinical team to discuss your treatment plan, did you talk about any of the following types of services to help you? (Describe to member and check all that apply.)

____ *Assertive Community Treatment*   A team with a doctor, nurse, case manager, peer support worker, and employment and housing case managers. You usually see someone from your assertive community treatment team once a day or multiple times during the week. The team assists you with support and services in the community.

____ *Supported Employment*   Supported employment helps you get a job that you are interested in. It can involve helping you think about what job you want, reviewing your job skills and needs for training, finding jobs you might want, preparing for interviewing or applying for a job, and supporting you once you have a job.

____ *Supported Housing*   Supported housing helps you find and maintain a good place to live. It might help you get the help you need to afford a place to live, work with the landlord when necessary, and make sure you have all the skills and support you need to stay in an apartment or other place to live. It might include coaching and help with the rent.

____ *Peer Support Services*   Peer support services are provided by another person who also receives behavioral health services and has similar lived experiences as you. It may include helping you find the right kind of services and talking to you about your recovery.

____ *Family Support Services*   Family support services helps your family be better at understanding and helping you. It may be provided by a family mentor at your clinic.

2. Are any of these services in your most recent individual service plan?

____ Yes   ____ No

3. Do you think that you need any of these services?

___Yes

    ___Assertive Community Treatment
    ___ Supported Employment
    ___ Supported Housing
    ___ Peer Support Services
    ___ Family Support Services

___No

APPENDIX D

GROUP 2 MEDICAL RECORD REVIEW TOOL

Log-in screen [1]

Reviewer Name _____ Client ID _____ DOB ___/___/___

Date _____/_____/_____ Provider Network Organization _____ Direct Care Clinic_____

Date of most recent assessment ___/___/___   Date of most recent ISP___/___/___   Sample period: *January 1, 2017 – December 31, 2017*

Chart Review [2]

	Functional Assessment Need (as documented by the clinical team) [2A]	ISP Goals Need (as documented by the clinical team) [2B]	Is the documented need consistent with other information (e.g., client statements, assessment documentation) [2C]	ISP Services (record any relevant service(s) referenced on the ISP [2D]	Evidence of Service Delivery Consistent with ISP [2E]	Reasons Service was not Delivered Consistent with ISP [2F]
ACT						
Supported Employment						
Supported Housing						
Peer Support Services						

APPENDIX E

SUMMARY OF RECOMMENDATIONS

Service	Recommendations
Peer Support Services (PSS)	PSS 1: Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including peer support. PSS 2: Perform initial and ongoing training to clinical team members to differentiate between a recovery model and a medical model of behavioral health service delivery, how to utilize a recovery oriented approach in interacting with members and how to apply recovery oriented language in documenting the individual's recovery. PSS 3: For those members who are less engaged with the clinical team, or who have made minimal progress with treatment goals in the preceding year; invite those members to work with a peer support specialist to develop a recovery plan that can inform the annual assessment and individual service planning process.
Family Support Services (FSS)	FSS 1: Ensure the consistent application of privacy practices at the direct care clinics to balance compliance with member confidentiality while providing opportunities for involved family members to participate in the member's care as appropriate and consistent with the member's choice. FSS 2: Ensure through training and ongoing supervision that direct care clinical team members, including case managers and clinical supervisors, understand the appropriate application of covered behavioral health services, including family support. FSS 3: Provide additional training and supervision to recognize the value of family support services as effective service plan intervention.

Service	Recommendations
Supported Employment Services (SES)	SES 1: Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and/or maintaining employment. SES 2: Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported employment services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services. SES 3: Monitor (and take actions as appropriate) the observed practice of indiscriminately documenting supported employment services on members' individual service plans without evidence of an assessed need for the service. SES 4: Create educational materials, available in the lobbies of the clinics, which describe basic information about employment and its impact on member health and welfare benefits. SES 5: Use peer support specialists to engender interest in working by hosting groups and other forums in which peer support specialists "tell their story" about the benefits of finding and maintaining employment. SES 6: Incentivize and reward supported employment providers that successfully transition members from pre-job training and development services to job search and job maintenance services. SES 7: Review the effectiveness of current provider monitoring activities to ensure that individual service plans are based on the member's assessed needs and are specific to the member's individual circumstances. When performance deficiencies are identified, initiate remedial actions with providers including technical assistance, performance improvement initiatives and/or corrective action plans. SES 8: Standardize job responsibilities and functions for required rehabilitation specialist staffing positions, including clarification regarding the direct provision of supported employment services. SES 9: Ensure contractual requirements for assigning rehabilitation specialists to each clinical team are met and take appropriate actions if staffing vacancies persist or reoccur with contracted providers.
Supported Housing Services (SHS)	SHS: 1 Promote more robust clinical supervision and oversight of case managers and other direct care clinic team members that ensures regular and timely consultation to address the ongoing supported housing needs of members. SHS 2: Through training and supervision, ensure that clinical team members understand the appropriate application of covered services designed to meet a person's objective and goal of securing and maintaining independent living arrangements. SHS 3: Establish regular monitoring and performance improvement activities to address instances in which the clinical team identifies supported housing services as a need and/or documents the service on the member's individual service plan but does not initiate or follow through with referrals to secure the services.

Service	Recommendations
Assertive Community Treatment (ACT)	ACT 1: Continue efforts to actively facilitate the identification of appropriate candidates for ACT team services through the regular analysis of service utilization trends, service expenditures, and the review of jail booking data, quality of care concerns and adverse incidents involving SMI recipients. ACT 2: Consider expanding referral sources that can identify and recommend members to forensic ACT teams and utilize available data to inform decision making. For example, utilize cost and criminal justice recidivism data to identify potential candidates for these specialty ACT teams. ACT 3: As part of the annual assessment update, intentionally review the member's assigned level of case management (i.e., connective, supportive, ACT) and determine if the member is assigned to the appropriate level of case management. As part of the annual assessment update, document that this review occurred. ACT 4: Clinical teams should regularly evaluate opportunities for current ACT team members to step down to a lower level of care as clinically appropriate and document when these reviews occur as part of the member's medical record.
General Recommendations	GR 1: There is currently no systematic process in place to assess the validity of the provider self-reported data. Based on Mercer's recent experience with reviewing medical record documentation, it is recommended that the RBHA establish a process to validate the provider self-reported data regarding current assessments and individual service plans.

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